

What makes therapy work?

RUNNING HEAD: WHAT MAKES THERAPY WORK

School of Psychology and Speech Pathology

Division of Health Sciences

What makes therapy work? An exploratory study of the
understandings of 'expert' psychotherapeutic practitioners

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Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Signature:

Date:

Acknowledgement

Coming from a bookish family, I recall receiving a copy of Homer's Odyssey on my seventh birthday. Penned in black ink, my stepfather's inscription warned this was my "introduction to life's journey". And I read of the voyages of Ulysses for years enthralled by the challenges he faced. So, as I reflect upon the doctoral experience and this acknowledgement, my stepfather's words resound. I certainly recognize my Scylla and Charybdis who threatened to wreck my thesis aspirations. But, more importantly, I acknowledge my Athena and Hermes who brought me home in exigent circumstances. In addition, as with all myths and legends, there are a small band of less-known protectors who must be honoured for their role in the protagonist's journey. Hence, in no particular order, I wish to pay tribute to those individuals who ensured my thesis endeavour reached fruition.

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Although I am aware the thesis passage forged a stronger internalized Ithaca, I am keenly conscious its challenge continues. Thus I heed Campbell's (1949) cautionary words that “the returning hero, to complete his adventure, must survive the impact of the world (p.39)”. Like Odysseus, I hope to travel life's road with more awareness, strengthened by realizations that emerged on the thesis path. In part these insights are the legacy of my mother's resourcefulness and my father's fortitude. Yet as convention dictates enhanced personal qualities are the reward of the hero's journey, I believe this to true of the doctoral experience. With this in mind, I dedicate this dissertation to the memory of Leontine, my paternal grandmother, whose spirit has guided me throughout life.

Abstract

This thesis explores the informants of effective psychotherapy derived from subjective and intersubjective practitioner/researcher perspectives. Unlike the empirical model of rationalist, objective precepts, these understandings stem from inductive reasoning that incorporates Aristotle's (1976) notion of *phronesis* and Schön's (1983) model of reflective practice. Essentially, this approach examines the tacit knowledge of 'expert' psychotherapists based on multiple collaborative, iterative-generative conversations. Accordingly, this process generated grounded theory characterized by a series of interrelated themes. The most significant of these established that client internalized second-order change is a primary feature of effective psychotherapy. It was also ascertained that client enhanced self-concept and subjective and objective change contribute to internalized second-order change. Secondly, client symptomology, psychological mindedness, reflexivity and openness to change were also viewed as major factors in facilitating this outcome. Thirdly, therapist contributions were recognized as important informants of effective psychotherapy. These include a commitment to emotional truth, authenticity, receptivity, therapeutic presence, clinical acumen and adoption of participant/observer and executive/caring stances. Fourthly, a number of interpersonal processes were identified as influential shapers of client second-order change. Specifically, the relational depth of the client/therapist encounter informed by the parties' mutuality was considered pivotal. Fifthly, therapeutic turning points operating at covert and overt levels of awareness were highlighted. In keeping with informed discourse, these therapeutic events are described as therapeutic moments, vulnerable moments and present moments. Sixthly, a model of therapist empathy thought to enhance these critical encounters emerged. Finally, a six-phased transtheoretical model to facilitate practitioner effectiveness was presented based on the study's overarching themes.

Contents

Declaration	ii
Acknowledgement	iii
Abstract	v
PROLOGUE	1
What Makes Therapy Work?	1
A Tale of Two Paradigms: Techne and Phronesis	2
Features of Phronesis	9
CHAPTER ONE	15
WHAT MAKES THERAPY WORK?	15
REVIEW OF THE EMPIRICAL LITERATURE	15
Assumptions of Previous Research	16
Thesis Philosophical Assumptions Challenge	19
Two Strands of Existing Empirical Research: Outcome & Process....	21
Outcome Enquiry	22
Process Research	24
Outcome Literature: First Strand of Empirical Inquiry.....	25
Does Psychotherapy Work?	26
Criticisms of Outcome Research	30
Qualitative Outcome Studies: An Alternative Paradigm	32
Process Research: Second Strand of Empirical Inquiry.....	33
Historical Development of Process Research.....	34
Specific & Common Factors in Outcome Literature	37
Specific Factors: Battle of the Brands.....	38
What Are Common Factors?.....	40
History of Common Factors	40

Client Factors	42
Relationship Factors	46
Placebo Hope and Expectancy Factors	53
Model/Technique Factors	54
Criticism of Common Factors Line of Inquiry.....	55
Events Paradigm in Process Literature	59
Common Themes in Process Research.....	64
Overt and Covert Processes in Psychotherapy	65
Overt Processes: Rogers' Core Conditions	67
Covert Processes: Meaningful Moments and Transference Relationship	77
Criticism of Process Research Line of Inquiry	85
Conclusion to the Literature Review	93
Chapter One Schematic Outline	97
Literature Review	97
Empirical Literature on Effective Informants	97
CHAPTER TWO	98
FOUR INTERRELATED LEVELS OF DESIGN	98
Ontological Concerns	99
Epistemological Concerns	100
Significance of Practice Wisdom	107
Explicit, Implicit and Tacit Knowledge.....	110
Reflexive Praxis.....	115
Methodology, Methods, and Procedures	125
Methods and Procedures: Constructivist Bricolage	136
Meaning of Method	137

Bricolage.....	137
Research Populations	138
Construction of Research Material.....	144
Analysis of Research Material.....	150
Grounded Theory	150
Trustworthiness of the Study	156
Generalizability of the Study	161
Summary of Design Considerations	166
Chapter Two Schematic Outline (Part A)	169
Methodological Design of Study	169
Four Interrelated Design Levels	169
1. Ontological Considerations	169
2. Epistemological Level	169
3. Methodological Level	169
Chapter Two Schematic Outline (Part B)	170
Dominance of Bricolage	170
Multiple Methods	170
4. Methods and Procedures	170
Chapter Three	170
Phase One Findings.....	171
CHAPTER THREE	171
ATTRIBUTES AND INFORMANTS OF EXPERT PRACTICE.....	171
Overview of Phase One	172
Overarching Theme 1: Cognitive, Emotional, Relational Expertise	172
Sub-Theme 1.1: Cognitive Expertise.....	178
Sub-Theme 1.2: Emotional Expertise.....	180

Sub-Theme 1.3: Relational Expertise.....	182
Implications of Theme 1: Attributes of Expertise	184
Limitations of Theme 1	188
Theme 2: Informants of Cognitive, Emotional and Relational Expertise.....	189
Sub-Theme 2.1: Personal Informants.....	190
Sub-Theme 2.2: Professional Informants	192
Discussion of Theme 2: Personal and Professional Informants of Expertise.....	193
Personal Informants of Study and North American Research	194
Professional Informants of Study and North American Research ...	201
Implications of Theme 2: Personal and Professional Informants of Expertise.....	211
Limitations of Theme 2.....	218
Chapter Three Schematic Outline (Part A)	222
Phase I: Features of Expert Psychotherapeutic Practice	222
Findings: Overarching Theme & Associated Sub-Themes.....	222
Chapter Three Schematic Outline (Part B)	223
Findings: Overarching Theme & Associated Sub-Themes.....	223
Phase I: Informants of Expert Psychotherapeutic Practice.....	223
CHAPTER FOUR	224
PHASE TWO FINDINGS: WHAT MAKES THERAPY WORK?	224
Overarching Theme 1: Internalized Change Informs Effective Therapy	225
Sub-Theme 1.1: Enhanced Sense of Self Supports Client Internalized Change	232
Sub-Theme 1.2: Client Objective and Subjective Change.....	235

Summary of Theme 1: Client Internal Second-Order Change	240
Overarching Theme 2: Contribution of Clients.....	241
Sub-Theme 2.1: Client Symptoms.....	241
Sub-Theme 2.2: Client Psychological Mindedness	248
Discussion: Meaning of Psychological Mindedness	250
Sub-Theme 2.3: Client Reflexivity	253
Sub-Theme 2.4: Client Openness to Change	258
Discussion: Client Openness, Receptivity and Readiness for Change	260
Summary of Theme 2: Client Contribution to Change	265
Overarching Theme 3: Contribution of Therapists	266
Sub-Theme 3.1: Therapist Commitment to Emotional Truth	267
Sub-Theme 3.2: Therapist Authenticity.....	271
Sub-Theme 3.3: Therapist Presence.....	277
Sub-Theme 3.4: Therapist Receptive Listening	281
Sub-Theme 3.5: Participant-Observer Stance	286
Sub-Theme 3.6: Executive and Caring Functions	290
Sub-Theme 3.7: Therapist Acumen	293
Summary of Theme 3: Therapist Contribution	298
Chapter Four Schematic Outline (Part A)	300
Phase II: What Makes Therapy Work.....	300
Chapter Four Schematic Outline (Part B)	301
Phase II: What Makes Therapy Work.....	301
CHAPTER FIVE.....	302
PHASE TWO FINDINGS: WHAT MAKES THERAPY WORK?	302
Interpersonal Processes	302

Overarching Theme 1: Relational Depth	304
Sub-Theme 1.1: Mutuality.....	309
Sub-Theme 1.2: Moments of Meeting.....	316
Sub-Theme 1.3: Relational Presence	321
Sub-Theme 1.4: Therapist/Client Realness.....	326
Sub-Theme 1.5: Client/Therapist Receptivity	330
Summary of Relational Depth and its Attributes	333
Overarching Theme 2: Significant Moments and Client Change	334
Sub-Theme 2.1: Significant Moments.....	336
Sub-Theme 2.2: Therapeutic Moments, Client Change and Effective Therapy	338
Sub-Theme 2.3: Vulnerable Moments	344
Summary of Significant-In-Session Moments Paradigm	348
Overarching Theme 3: Informants of Significant In-Session Moments	349
Sub-Theme 3.1: Empathic Inquiry	349
Sub-Theme 3.2: Empathic Imagination.....	352
Sub-Theme 3.3: Empathic Immersion	355
Sub-Theme 3.4: Empathic Attunement	357
Summary of Informants of Significant-In-Session Moments	361
Significance of Findings of Phase Two of this Study.....	362
Implications of Researcher Position in Phase Two.....	362
Implications of Phase Two Substantive Findings.....	366
Training and Professional Development Implications	369
Limitations of the Phase Two Findings	370
Chapter Five Schematic Outline (Part A)	374

Phase II: Interpersonal Processes That Make Therapy Work	374
.....	374
Chapter Five Schematic Outline (Part B)	374
Phase II: Interpersonal Processes That Make Therapy Work	374
Chapter Five Schematic Outline (Part C)	375
Phase II: Interpersonal Processes That Make Therapy Work	375
Epilogue.....	376
Practice Wisdom.....	376
SIX 'C' MODEL OF EFFECTIVE THERAPY	377
A Model of Phronetic Process: The Six 'C's' of Psychotherapy	381
Final Word	394
Epilogue Schematic Outline (Part C)	396
Exemplar of Practice Wisdom	396
Six 'C' Process Model of Effective Therapy.....	396
APPENDIX 'A'	397
APPENDIX 'B'	398
APPENDIX 'C'	402
APPENDIX 'D'	403
APPENDIX 'E'	406
APPENDIX 'F'	408
APPENDIX 'G'	412
PHASE TWO: EXPERT SUMMARY AUDIT	412
References	415

PROLOGUE

What Makes Therapy Work?

Where is the wisdom we have lost in knowledge?

Where is the knowledge we have lost in information?

Eliot, T.S. (1934). Choruses from the Rock, p.161

Although the question 'what makes therapy work' is by four generations of empirical research, findings remain contentious. In an attempt to add to this discourse, this study investigates the informants of effective psychotherapy from the viewpoint of West Australian practitioners considered 'experts' in their field. As an ancillary issue this inquiry also reviews the meaning of 'expert' praxis within this context. By privileging practice wisdom in this way, this study highlights a key feature in previous research that represents the major focus of this prologue. This refers to the tension between propositional and procedural forms of knowledge and its divisive effect on psychotherapeutic research. Accordingly, initially a précis of these notions derived from Aristotle's (1976) paradigms of *techne* and *phronesis* is presented. The relevance of these constructs to the zeitgeist of Australian tertiary education advanced by Schwartz (2010) is also included. In addition, Polkinghorne's (2004) insights regarding the meaning and impact of these constructs upon the domain of psychotherapy are also reviewed. As these themes are central to this research, they are re-examined in the final word of this dissertation, the epilogue.

In reflecting on the thrust of this exploration that focuses on the understandings of psychotherapists, the role of practice wisdom is central. Breaking with the traditional empirical stance that favours technological scientism, this approach privileges judgment- based praxis (Hudson, 1997; Polkinghorne, 2004). Indeed, this dominant discourse of positivistic rationalism, derived from experimentation and evidence-based inquiry, consistently devalues and marginalizes praxis forms of knowledge development (Berger, 2002). Thus most psychotherapeutic professionals embrace the tenets of this modernist position, accepting that standards of praxis and research are primarily informed by evidence-based views of science. However this stance is not particular to psychotherapy or the psychological sciences. Indeed Berger (p. 4) asserts “this ethos underpins an ascendancy of technocracy” that has operated for centuries in a wide variety of realms. Putman (1983) argues this emphasis reflects an “obstinate insistence that the methods of the natural sciences are of universal application in an uncompromising thesis which brooks no opposition...in which no alternative deserves to be taken seriously” (p. 288).

Nevertheless, despite the dominance of this Cartesian view, the supremacy of technocracy is extensively criticized. For instance Olasfon (2001) views this form of naturalism as a “totalitarian view of science” (p. 7) and provides a comprehensive philosophical critique of objectivist science. Other criticisms focus on the shortcomings of a rationalist ontology that overlooks the relevance of a social science based on human behaviour (Bernstein, 1971). Indeed, this thesis is substantively informed by these critical accounts of a technocracy embedded in the Aristotelian notion of praxis. As this is rarely explored within psychotherapy research, it is helpful to refer to the constituents of this notion Aristotle (1976) identifies as *techne* and *phronesis*.

A Tale of Two Paradigms: *Techne* and *Phronesis*

Essentially, *techne* refers to the creation of knowledge required to craft objects within the physical realm whilst *phronesis* refers to complex social practices within human experience that lead to knowledge generation. . Based on Aristotle’s (1976) conceptualisation, Polkinghorne

(2004) suggests *techne* embodies technical rational decision-making that is viewed as normative in modern society. This stance is based on the privileging of scientifically validated propositions and principles to attain pre-determined goals. Described variously as instrumental reasoning (Weber, 1981), means-end reasoning and strategic reasoning (de Certeau, 1984), Polkinghorne represents *techne* as “technical rational practice” (p. 27) that occurs within a “technified culture” (p. 35) committed to the making of artefacts. This model espouses mathematics, geometry and the principles of classical rationalism are mandatory to achieve specific ends. Essentially, this reasoning is thought to produce conclusions that are universally held to be true (Brown, 1988).

In contrast to these precepts, Aristotle’s depiction of *phronesis* envisages a different kind of knowledge to *techne* that individuals construct within society to live well. In this context Bernstein (1971) describes this as “doing proper, where the end or *telos* of the activity is not primarily the production of an artifact but rather the performance of a particular activity in a certain way” (p. xii). Indeed Aristotle coins this conduct as “practices of the good” and emphasizes they occur within the human realm (Polkinghorne, 2004, p. 2). Accordingly he coins these activities as expressions of *praxis* to distinguish them from *techne*’s technological decision-making. In attempting to clarify this notion Berger (2002) contends *praxis* is ethical, responsible individual and community conduct that constitutes legitimate, non-technical, non-rational reasoning. In particular he contrasts *praxis* with *techne* by stating the former is not “captured by formal-logical, explanatory schemas” (p. 41).

In describing the thrust of *phronesis*, Aristotle (1976) makes the point it embodies knowledge that enacts *praxis* in a responsible and appropriate manner. Hence *phronesis* is personal and experiential, characterised by perceptiveness, responsiveness and flexibility. Essentially, Aristotle maintains this phenomenon is not limited to the mastery of a skill or theory, but constitutes the ability to recognize saliency and respond to real-life situations with imagination and resourcefulness. Thus, in contrast to *techne* knowledge that centers on understanding conceptual and theoretical

meanings, *phronesis* concerns itself with knowledge gleaned from practical responses to experiential encounters. Accordingly, *phronesis* informs *praxis* knowledge that cannot be responded to by universal laws, absolutes, technological mastery, and methodological purism. In effect, this kind of approach applies to circumstances that are innately unpredictable and rife with subjectivity and value judgments (Smith, 2009).

This description of *phronesis* contrasts with the knowledge that typifies *techne*. Berger (2001) describes the latter as “the thin world of primary attributes with which science deals and where technical/instrumental rationality is the appropriate modality” (p. 42). Unlike *techne*, Aristotle (1976) posits *phronesis* cannot be acquired ‘objectively’ by analyzing a phenomenon through a program of formal study. Rather, it requires a formative process in which a special kind of experience and the development of “right character are intertwined reflexively” (Berger, p. 44). Interestingly, Aristotle does not address the nature of this ‘formative process’ or articulate the exact meaning of ‘right character’ although these notions are explored by various scholars. In attempting to clarify the differences between *phronesis* and *techne*, Nilsson (2010) postulates the former is a kind of knowing in which we “see ourselves” without objectification (p. 77). Moreover in describing *phronesis* Heidegger (1924-1925) suggests human beings are incapable of experimenting or being ‘objective’ about the self. In contrast to *techne*, he postulates *phronesis* involves an intimate kind of self-knowledge that fails to make the self “available” for experimentation (p. 54). Smith (2009) makes the point that Aristotle views *techne* as “a productive state that is truly reasoned” (p. 208). Such a stance views human beings as agents with technical skills engaged in knowledge production and craft development that aims at specific objectives. Alternatively, Smith asserts individuals engaged in *phronetic* practices focus on who they are or who they are becoming through this process. Indeed, Dunne (1993) submits *phronesis* does not seek to “maximize a ‘good’ that one already knows and can come to have, but rather – a much more difficult task – to discover a good that one must become “ (p. 270). Thus, through the lens of *techne*, the world is

viewed in terms of its usefulness: trees are perceived as lumber, rocks are perceived as stone blocks for building, and animals are considered as food and material for clothes (Chu & Tsui, 2008). Alternatively, *phronesis* enables trans-generational modification to the culture of a community based on experience and insight. Therefore, through the lens of *phronesis*, societal traditions, customs, habits, and laws are perceived as human decisions in context informed by changing situational circumstances.

Nonetheless, despite the sophistication of *phronesis* that embraces the diverse practices of human beings, this paradigm creates ambiguity and unpredictability in knowledge generation. Specifically, it lacks the certainty and security of *techne* constructs that derive from a reductionist, objectified externalized 'truth' (Polkinghorne, 2004). Alternatively, as *phronesis* stems from the application of complex conceptualisations and theories, its practices frequently require explication through metaphors and myths that are not always easy to grasp. In essence, these polarized models of *techne* and *phronesis* impact on knowledge creation and societal development.

To add to this schism, Aristotle (1976) identifies a struggle for supremacy between these two competing perspectives. In particular, he argues that society is likely to remain stagnant if the ethos of *techne* dominates its beliefs and values even though the security of its polis is assured. Nonetheless, despite this benefit, Aristotle concludes *phronesis*, rather than *techne*, constitutes the preferred method of communal organisation (Chu & Tsui, 2008). This decision stems from the view that a society informed by *phronesis* ensures the advancement of more sophisticated levels of personal and communal responsibility. Significantly, *phronesis* offer societal members the freedom to determine the character of their community and the nature of their crafts. As Falkam (2008) posits, Aristotle opts for this alternative rather than *techne* ideals that empower those who control technology to determine the cultural and economic life of its citizens.

Although efforts to define *phronesis* are relevant to the thrust of this thesis, other scholars besides Aristotle (1976) also attempt to stress the

importance of practice wisdom. In a recent keynote address beseeching the restoration of practice wisdom to universities, the Vice-Chancellor Schwartz (2010) of Macquarie University argues the merits of phronesis by pointing to Confucian concepts articulated in the fourth century B.C. Schwartz posits these precepts offer three ways to gain wisdom: through reflection, imitation and experience. Schwartz also defers to Gu Yanwu, the seventeenth century Chinese sage who asserts that to become wise one must read ten thousand books and walk ten thousand miles. According to Schwartz these metaphors and myths reveal the essence of practical wisdom that he defines as experiential knowledge that becomes increasingly sophisticated as it builds on book learning and experience in the field. Essentially, he asserts these philosophers postulate one must know how to act on book knowledge to achieve beneficial outcomes in any realm. In particular, Schwartz stresses technological knowledge is insufficient without appropriate experience, mentoring and reflection. In other words, although Schwartz maintains *techne* book learning is necessary if one is to become wise, he makes the point more is needed if society is to progress. Accordingly, he defines practice wisdom as a combination of moral will and moral skill, embodied in understandings of the 'right' thing to do and how this may be achieved. Hence although both scholarly knowledge and practice wisdom are essential features in the evolution of any domain or discipline, phronesis presents more advanced level of knowledge-in-action. Moreover, this trend is linked to societal progression prefaced on personal and communal responsibility described by Aristotle (1976) as 'right character'. Similarly, Buddha's notion of 'right action' infers comparable attributes to phronesis.

Nevertheless, despite Schwartz's (2010) plea to move from knowledge generation dominated by technocracy to an acceptance of phronetic practice, it seems the significance of the latter is diminished in modern society by an increasing preference for the *logos* of *techne* (Tsang, 2008). Thus a close investigation of how this is enacted within the broader framework of modern society is offered prior to examining the implications of this trend within the domain of psychotherapy. The rationale for this

approach stems from the belief that an understanding of these contextual influences is pertinent to the considerations that underpin the thesis question.

Techne and Phronesis in Modern Society

In view of Aristotle's (1976) reservations about *techne* and Schwartz's (2010) plea to "wise-up" (p. 1) universities, contemporary philosophers and ethicists such as Flyvbjerg (2006) protest that the significance of *phronesis* has been forgotten in modern society. They charge human beings are choosing to live in a world that accepts the primacy of a technology that devalues practice wisdom. Social commentators increasingly contend that although this privileging of *techne* produces unprecedented affluence in an endless over-supply of consumer goods and services, this development fails to 'advance' society. They bemoan the fact this abundance stems from the desire to control, positing this has left society increasingly ignorant of its original purpose. Indeed Tabachnick (2004) argues technologically-prescribed standards are becoming more and more ubiquitous as community members become less and less certain of their purpose. Accordingly, he charges that we, as members of this polis are now mastered by this technocracy. Hence, increasingly, social scientists claim that consumer advancement has come to subordinate human needs to maintain its supremacy. By way of example Schwartz argues that "universities were once in the business of character-building but now they exist in an age of money and money is what the modern university is all about". Thus he maintains that university courses are progressively more vocational as individuals are programmed to work in a polis of technology. Nonetheless, Schwartz makes the point that successful careers depend on much more than development of technical skills. Indeed, although he stresses they depend on the application of practical wisdom, he bemoans the fact that modern universities are not in the wisdom business. Thus, it may be argued that the unfettered application of knowledge informed by *techne* eschews practice wisdom and is deficient for this reason.

Accordingly, this thesis is a small effort to address this imbalance by illuminating the advantages of *phronesis* in the generation of knowledge.

Unlike Aristotle (1976) this stance does not demote the paradigm of *techne* or the paradigm of *phronesis* but views both paradigms as co-constructors and collaborators in the business of knowledge development. Accordingly, as this thesis examines the tensions between these models and their effect on the development of psychotherapeutic knowledge, the next stage of this prologue examines this polarization more closely.

Tension of Techne and Phronesis Polarity

Although this research primarily celebrates phronetic understandings gleaned from the collective wisdom of expert psychotherapeutic practitioners, it also acknowledges the contribution of *techne*. Indeed empiricism is not discarded as propositional knowledge gleaned from scientific experimentation is valued for its observation and sensory experience. However it is argued that sole reliance on this position within the human domain is limited as it is based on the natural science premise that an objective 'truth' of a phenomenon may always be identified. Indeed, such an approach captures the belief that good observation by objective inquirers will ultimately lead to the realization of good data and valid research (Tabachnick, 2004). Accordingly a critique of this universal generalization lies at the heart of this response to the thesis question.

Although a full review of empiricism is beyond the scope of this prologue, this method of knowledge construction is open to criticism within the human sciences. Essentially, a constructivist position, adopted by this inquiry, posits this form of research fails to recognize that observation is a subjective process connected to the in-situ circumstances of the person who undertakes the observation. In addition, it is argued that an object of perception cannot be distinguished from the circumstances of the individual who perceives it, just as knowledge cannot be separated from the knower. However the objective, determinism of empiricism ignores these subjectivities and contextual realities that characterize the human dimension. Yet, within the landscape of psychotherapy research, empirical randomized control trials and rationalist meta-analyses are the preferred method of inquiry, routinely utilized to establish what makes therapy work. Nonetheless, despite four decades of these positivistic efforts, responses to

this question remain enigmatic and vague. Thus, as it cannot be denied that the privileging of techne has produced disappointing results, it is suggested that the practice wisdom may offer more insight into what makes therapy work. Accordingly, the next task of this discussion attempts to articulate current principles of practice wisdom espoused by the helping professions as a precursor to exploring their application to the domain of psychotherapy and the thesis question.

Features of Phronesis

As this research thrust centers on the phenomenological understandings of West Australian expert psychotherapeutic practitioners, it seeks to explore the procedural knowledge of phronesis. Unlike the explicit, declarative knowledge of techne's empiricism, this investigation aims to glean the implicit and tacit understandings of therapist wisdom. Although Schwartz (2010) offers a contemporary definition of practice wisdom, it is instructive to consider definitional notions that emanate from the helping professions. However although a close exploration of the relevant literature reveals this notion is rarely discussed within this context, the domain of social work offers some guidance. Chu and Tsui (2008) posit practice wisdom within this context is a collective term that refers to knowledge gleaned from sources other than technical, rational, reasoning. Dybicz (2004) adds practice wisdom is acquired through embodied reasoning derived from personal experience, mediated by emotion, relational dynamics, and the creative imagination. Chu and Tsui also contend practice wisdom crystallizes when intersubjective intuition is embodied in action although this generally occurs beyond the realm of practitioner awareness. This position assumes phronesis is heuristically derived as relevant issues are identified during the process of remedial action (Deroos (1990). Finally, Chu and Tsui conclude practice wisdom manifests when specific acts are enacted at particular times in particular situations informed by ongoing reflection. Accordingly, this results in complex tacit, implicit understandings embodied in human action.

Phronetic Psychotherapy

The viewpoint adopted in this thesis holds that practitioners of psychotherapy adopt different assumptions about the predictability of human actions than those informed by the inferential logic of traditional research (Polkinghorne, 1996, p. 1429). This reasoning is based on the belief that the practice of psychotherapy generates wisdom that transcends the application of purist, formal theory. Essentially this kind of praxis judgment is sensitive to changing contextual considerations. Accordingly this empowers practitioners to combine formal knowledge of relevant concepts and previous experience to make sense of new contexts. This generally necessitates the development of alternative explanations, interpretations and actions to deal with new specificity. Thus practice wisdom fails to conform to the techne paradigm as its tacit and intersubjective nature is inevitably linked to human judgment (Polkinghorne, 2004; Yuen, 2004; Zeira & Rosen, 2000). With this in mind, it is suggested psychotherapy practitioners are increasingly challenged by the growing emphasis on evidence-based research as the predominant form of inquiry needed to legitimize knowledge generation (Sackett, Rosenberg, Gary, Haynes, & Richardson, 1996). Accordingly, many therapists assert there are aspects of professional practice that do not fit within this model. Specifically, they point to professional skills essential to therapeutic effectiveness that do not meet the criteria of evidence-based practice. This is a substantive conundrum as psychotherapy represents a realm of knowledge generation in which evidence-based research is increasingly valued. This difficulty takes on a paradoxical quality when the historical development of this discipline is reviewed. Specifically, on the one hand psychotherapy has a long history associated with psychiatry and the tenets of the medical model. Yet, on the other hand, psychotherapeutic praxis increasingly focuses on relational, intersubjective aspects of the human dimension (Renolds, 2007). Although the challenge of these competing trends is muted by the current bent to subordinate practice wisdom, this thesis raises questions as to whether both forms of inquiry may be equally valued. In particular, it reflects on whether it possible to reconcile the

operation of *techne* and *phronesis* as partners in the development of legitimate therapeutic knowledge.

This question is addressed in a review of existing empirical studies by Ogles, Anderson, and Lunnen (1999). These researchers conclude 'good' clinical practice does not result from theoretical training, awareness of the clinical literature, adoption of empirical research, or from instructions regarding appropriate intervention. Instead they argue 'good' clinical praxis emerges from the combination of the therapist's personality, attitudes, and way of being with clients. In substantiating this argument they point to the Aristotelian notion of *episteme*. As this is commonly described as academic knowledge, Ogles et al., submit this is crucial in providing a solid foundation to underpin clinical practice. Moreover *episteme* operates as an important holding function that enables practitioners to "maintain equanimity in the challenging setting" (Almond, 2003, p.131) of the therapeutic relationship. Similarly, therapists are obliged to acquire a broad range of *techne* skills in the form of strategies that tailor treatments to the individual needs of clients. However Ogles et al., emphasise they view practice as the most significant determinant of successful therapy based on their understandings of Aristotle's (1976) notion of 'prudence':

Prudence is not concerned with universals only; it must also take cognizance of particulars, because it is concerned with conduct, and conduct has its sphere in particular circumstances (p.213).

Indeed this position claims therapeutic effectiveness depends upon "knowledge of particular facts, which become known from experience" (p. 215). Jørgensen (2004) adds that more personal, less specific, common factors become important within this realm. This position calls for closely supervised clinical training and experience with a broad spectrum of clients with differing problems. Accordingly, Jørgensen emphasises this demands a combination of highly developed relationship skills, clinical judgment, and basic clinical skills. Finally, in view of the concerns of the thesis question, this prologue examines whether the principles of *phronesis* and *techne* may be combined to determine what makes therapy work.

Phronesis and Techne in Effective Psychotherapy

In keeping with Aristotelian reflection, numerous psychotherapeutic scholars have continued to polarise the domains of techne and phronesis. Accordingly, this thesis attempts to outline research and commentary from both these perspectives that seeks to identify the attributes of expert psychotherapy and effective therapeutic praxis. Initially, this involves an extensive literature review that tracks scholarly opinion and rationalist research that attempts to answer this question. In the main, this captures practice understandings derived from the dominant culture of techne. However some discussion of the qualitative literature is also included. As a full account of these developments is beyond the parameters of this exploration, comments are restricted to common, influential key features. Specifically, outcome research that highlights the role of common and specific factors in effective therapy is critiqued. Moreover the function of clients, the therapeutic relationship, placebo effects, and modalities are examined in terms of their impact on therapeutic outcomes. As the empirical literature informs this discourse, these developments are reported in positivistic terms, although the assumptions that underpin these ideas are deconstructed in a critique of the outcome literature. Likewise, developments within the process realm and their impact on the emergence of knowledge regarding what makes therapy work are also revealed. Although the dominance of techne within the process sphere is less evident, empirical investigation that focuses on client centred research, significant events research, psychoanalytic process research, and process outcome research are stressed. Furthermore, overt and covert process inquiries that embody empirical and practice wisdom are also explored prior to a critique of this investigative approach. Moreover, as this thesis question focuses on the understandings of expert West Australian psychotherapists, the importance of phronesis is underscored in a review that traces the meaning of therapeutic mastery in the context of explicit, implicit, and tacit knowledge.

In keeping with the objective of this thesis, Jørgensen (2004) notes existing conceptualizations of the active ingredients of effective

psychotherapy are primarily hypothetical. In an extensive critique of this issue he submits that this view of therapeutic success is principally derived from clinical theory endorsed by practice. Although most theories concerning these mechanisms of change have some validity, Jørgensen argues more practice-based, contextual research is required to assess the pragmatic value of these theoretical conceptualizations and hypotheses.

Thus, in view of *techne*'s dominance in seeking to identify the determinants of effective therapy, this investigation turns to *phronesis* as a paradigm of psychotherapeutic knowledge that it considers is as valuable as technical empiricism. This decision is prefaced on the assumption that the latter, derived from the experimentation of randomized control trials and meta-analyses has limited relevance to this issue. Indeed the expansive literature review in the chapter that follows is testament to this fact.

Accordingly, the position adopted in this research recognizes the technologicalization of psychotherapy is instrumental to problem-solving undertaken through scientific theory and tested techniques. As this approach assumes that the empiricalization of psychotherapy is an expression of *techne*, it is asserted that sole dependence on this domain overlooks the contribution of dialogical, relational aspects. Indeed, such a limited view assumes the professional knowledge of psychotherapists is learned from treatment manuals based on the belief that techniques have the ability to be separated from the individual style of therapists as well as the unique problems of clients.

Before completion of this prologue a personal reflection that addresses the dichotomy of *techne* and *phronesis* is presented. Although this study primarily seeks to explore practice wisdom with regard to what makes therapy work, it does not exclude that idea that the *techne*/*phronesis* polarity interact in any given circumstance. Yet, as a psychotherapy practitioner I am aware that the convergence of these paradigms frequently occurs in practice. Surprisingly, this meeting is rarely the subject of scholarly commentary. In keeping with this position, Smith (2009) points to clients who suffer from recurrent panic attacks or acrophobia and states therapists often apply a variety of cognitive behavioural techniques to

respond to client difficulties. Notwithstanding these efforts, it is suggested that therapy with the same client is likely to extend client aspirations beyond mere attendance to symptoms. Invariably, many individuals seek to become someone with the ability to manage their internal world more deftly. Nevertheless, Smith makes the point that such encounters that draw on both *techne* and *phronesis* are rarely reported. Indeed Smith posits these domains “often spill over into each other, with the former serving or becoming more akin to the latter” (p. 42). Smith also highlights the subtleties between *techne* and *phronesis* whilst Dunne (1993) proposes that exploration of Aristotle’s (1976) notions actually admits the possibility of a “*phronetic techne*” (p. 355). However it is interesting to note these perceptions exclude any suggestion of a “technical *phronesis*” (p. 42). Perhaps this omission captures a sophisticated form of irony that implies a *phronesis* that dominates *techne*?

Finally, given the level of detail in this thesis, a summary or ‘mud map’ is presented at the beginning of each chapter and main sections to provide a structure to guide a ‘lost’ reader. A summary sketch is also provided at the end of chapters as an attempt to bring the detail back to a broader level.

CHAPTER ONE

WHAT MAKES THERAPY WORK?

REVIEW OF THE EMPIRICAL LITERATURE

Everybody has won and all must have prizes

(Lewis Carroll, 1865)

Salient empirical research that examines the informants of effective psychotherapy is critiqued in this chapter. Initially, philosophical considerations underpinning this investigative thrust are discussed. As this ontological and epistemological stance adopts positivistic assumptions that privilege an externalized, objective reality, most postmodern critics condemn this approach as de-contextualized 'scientism'. Essentially these theorists assert rationalist restrictive assumptions ensure knowledge of the informants of effective therapy remains ambiguous and vague. They argue this kind of research is limited to two forms of inquiry: outcome effects and interpersonal processes. However, as each of these approaches views the other with suspicion, collaborative research development is limited. Hence commentators assert these constraints result in a proliferation of competing therapies coined the "battle of the brands" (Duncan, 2002, p. 35). This "deafening cacophony of rival claims" (Norcross & Grencavage, 1989, p. 229) is said to create further research fragmentation London (1988, p. 5) describes as "narcissistic fatigue". For instance 'the specific factors camp' of the outcome domain, proponents asserts ingredients of particular modalities are the primary determinants of effective therapy. However 'the common factors camp' argues elements found in all therapies such as client and therapist effects principally inform therapeutic success. Yet, despite their differences, both forms of outcome research reject process inquiry into therapeutic effectiveness as chaotic and unscientific. Adding to this divisiveness, the process domain attacks outcome inquiry as simplistic for its omission of contextual influences (Saltzman & Norcross, 1990). Thus, in the chapter that follows, this "therapeutic jungleplace" (Norcross & Grencavage, p. 229) is explored as the rationale for the praxis focus of the thesis question.

Assumptions of Previous Research

Despite more than four decades of empirical research, the determinants of effective psychotherapy remain elusive (Wampold, 2001). To some extent this uncertainty reflects modernist philosophical assumptions that privilege empirical experimentation. Essentially, this epistemological stance is informed by hypotheses-testing, statistical measurement, and quantitative assessment. Hence, the thrust to discover 'what makes therapy work' embodies positivistic ideals adopted by the psychotherapeutic domain (Jørgensen, 2004). These precepts illustrate a rationalist-realist stance to knowledge development, endorsed as the dominant discourse of research and praxis. Employing reductionist methods, this viewpoint asserts a number of "active ingredients" (Butler & Strupp, 1986, p. 30) initiate client change. Moreover, the presence of these change mechanisms is said to be indicative of effective psychotherapy. Consequently, these dynamics are classified into two distinct, recurrent influences identified in the literature as 'specific' and 'common factors' (Strupp & Hadley, 1979). As these notions play a central role in modernist empirical inquiry, a cursory overview of their meaning is addressed below, although a detailed account of their role in psychotherapy discourse is also explored later in this chapter.

Specific factors are ingredients, unique to particular theoretical orientations or modalities of practice thought to explain how people change in therapy. Essentially, its proponents argue different forms of psychotherapy are more efficacious than others. A recent meta-analysis examining adult depression (Cuijpers, van Straten, Andersson, & van Oppen, 2008) demonstrates this ethos. Essentially, this research ascertains both behavioural and psychodynamic therapy outperforms supportive, nondirective control conditions in alleviating depressive symptoms. Behavioural theory suggests depression stems from decreased positive reinforcement and increased aversive control from a person's environment, leading to avoidance and withdrawal behaviours (Ferster, 1973; Lewinsohn & Graf, 1973; Jacobson, Martell, & Dimidjian, 2001). Hence, behavioural therapists teach clients to monitor activity levels, encouraging them to

participate in actions likely to result in mastery and pleasure. On the other hand, psychodynamic theorists postulate depression stems from factors such as the repetition of internal conflicts through the loss of an early caregiver or a critical and withholding parent (Blatt, 1998). Working from a psychodynamic framework, therapists attempt to explore situations that lead clients to repeat these early mental conflicts. This is thought to help them understand the origin of their difficulties so that they may experience new, more beneficial encounters in the here and now.

Proponents of common factors, the other variable thought to induce effective therapy, argue that general, pan theoretical mechanisms lead to client change. Weinberger (1993) offers a definition asserting common factors constitute "effective aspects of treatment shared by diverse forms of psychotherapy" (p. 43). Essentially, this approach suggests interventions common to all psychotherapies rather than specific treatments lead to better outcomes (Cuijpers, 1998; Frank & Frank, 1991; Garfield, 1996; Henry, 1998; Klein, 1996; Wampold, 1997, 2001; Wampold, Mondin, Moody, Stich, Benson & Ahn (1997). This premise stems from the understanding that different modalities show similar effect sizes relative to one another. Thus, in the absence of more complex evidence, the common factors position contends the most parsimonious explanation for this equivalence should be accepted.

In response to a call for clarification, Kazdin (2002) contends therapies all work by the same mechanism although they are readily distinguishable from one another in theory and practice. Moreover, interventions shared by common factor orientations include relational connection, empathy, and acceptance (Wampold, 2001; Frank & Frank, 1991). Essentially, proponents of the common factors perspective postulate therapists draw on these attitudes to establish a strong therapeutic alliance. Accordingly, this attitudinal device constitutes the theoretical mechanism that effects substantive change in therapy. As further evidence of their viewpoint, supporters of a common factors model stress research suggests the alliance is a robust predictor of outcomes across all types of therapy (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Indeed,

Cuijpers et al. (2003) represents a cogent meta-analysis that evidences behavioural, cognitive, interpersonal, and psychodynamic therapies are approximately equal in their efficacy for treating depression.

Nevertheless, despite the view that specific and common factors constitute two divergent points of view regarding the causes of effective psychotherapy, they share much in common in terms of ontology and epistemology. Both stances foster the belief that optimal research 'uncovers' absolute truths in a knowable world that is 'out there' waiting to be discovered (Gergen, 2001). This approach privileges causal relationships between techniques and outcomes and generalizes this knowledge to other settings. In addition, specific methodologies authenticate this information through rigorous testing and replication that verifies universal principles. This approach argues researchers unearth the 'objective' causes of effective therapy through dependence on value-neutral truths. Hence this process of revelation constructs objective ideas that co-exist within a knowable world (Ponterotto, 2005).

Notwithstanding the pervasive influence of the rationalist positivistic perspective, the widening scope of postmodernist ideas questions this reliance on empiricism. Within this trend, relativist ontology refutes absolutism in its belief that reality is socially and linguistically constructed through subjective observation in a world of mutable multi-verses (Gillett, 1998). Contrary to modernist views, this approach endorses an epistemological pluralism that sanctions multiple ways of knowing (Morrow, 2007). Moreover, in keeping with this critique, modernist research examining the roots of effective psychotherapy in terms of specific and common variables suffers from a number of limitations. Although these empirical, evidence-based findings are empirically valid, they omit important questions that pose alternative ontological notions. As these constructs address different forms of knowledge, it is argued this critique is as legitimate as the rationalist-positivistic thrust that dominates psychotherapeutic investigation. However, even though these ideas are adopted by critical theorists to confront realist assumptions, psychotherapy researchers are more taciturn (Downing, 2004). Therefore, in an effort to

expand the parameters of traditionalist modernist inquiry, this research challenges the philosophical assumptions that underpin the specific/common factors dichotomy. Accordingly, it adopts a different ontological, epistemological, and methodological stance that is explored throughout this response to the thesis question.

Thesis Philosophical Assumptions Challenge

As the ontological and epistemological positioning of this study differs from the traditional tenets of rational empiricism, this distinction in perspective is addressed explicitly. Specifically, this research design relies on Pepper's (1942) notion of a world hypothesis to shape its methodological position. Pepper postulates diverse analytic positions described as formism, mechanism, organicism, and contextualism conceptualize different forms of knowledge. His approach relies on guiding principles known as root metaphors to drive each of these positions. Essentially, four separate lines of inquiry evidenced in the development of psychological ideas, are identified by Pepper. Formism, relying on the root metaphor of similarity, searches for patterns in diverse phenomena allied to psychology's quest to identify individual differences. Mechanism privileges reductionist objectivity that reflects psychology's empirical positivism focused on examination of component parts of a whole. Organicism, espousing the root metaphor of harmonious unity, considers integrative connections within a coherent whole. Finally, contextualism's root metaphor of an act-in-context explores past and present factors embedded in the experience of a single event (Bishop, 2007).

As the thesis question explores the causes of effective psychotherapy, the contextualist approach is viewed as most germane. This contextualist root metaphor addresses variant background influences integral to knowledge evolution (Gifford & Hayes, 1999). Pepper (1942) postulates contextualism embodies knowledge of an "act-in-context or historic event" (p. 232) that comprises common sense ways in which individuals understand experience. This understanding encapsulates a review of past events that become vivid and alive in the present. Thus an event and its setting are viewed as an integrated whole "in which the many

features of an action blend, both with themselves and with their context” (p. 289). Essentially, this world theory seeks to understand the richness of an event by a subjective understanding of all its features. Accordingly, as the everyday experience of expert psychotherapeutic practitioners provides in-depth knowledge of the therapeutic encounter, this falls within the act-in-context root metaphor. Consequently, as this position has the capacity to glean new knowledge regarding what makes therapy work, it adds to previous empirical findings. Having identified the philosophical stance that underpins this research, some comments regarding the application of this notion to client outcomes form the next task of this discussion.

Contextualist View

In reviewing the causes of effective therapy, the *current zeitgeist* of psychological research examines this question through rationalist empirical ideas. Accordingly, these investigations are experimental and quantitative in design, implementing systematic attitudes to problem-solving. This approach facilitates mathematical modeling and statistical estimation that lead to knowledge development (McLeod, 2001). Typically, a project begins with collection of data based on a hypothesis, followed by the application of descriptive or inferential statistics. Large volumes of data are collected that require rigorous validation, verification, and recoding. Causal relationships are examined by manipulating factors thought to influence the phenomena of interest. This is attained by controlling variables relevant to the experimental outcomes (Hill & Corbett, 1993). As this positivistic thrust is central to the identity of psychology, it is viewed as the sine qua non of all rationalist inquiry. A brief introduction to this form of scientism, rooted in observation and experimentation, is provided although a full appreciation of its scope is beyond of the parameters of this literature review.

Accordingly, the first phase of this literature review summarizes trends within the empirical literature that examine the causes of effective therapy and client change. In particular this approach highlights features that inform the outcome and process dialectic of evidence-based research. On completion of this generalized goal, the second phase of this chapter identifies and critiques specific research domains that review change

determinants within psychotherapy. Within the outcome literature this includes the “battle of the brands” (Duncan, Miller & Sparks, 2004, p. 31) raged by competing therapies aptly coined “the bonfire of the vanities” (Duncan, 2002, p. 34). The duality of specific and common factors and the infamous Dodo Bird verdict are also examined (Rosenzweig, 1936), together with the taxonomy of common factors that dominates the outcome domain. A critique of this line of inquiry is presented before this review turns to the process domain. This highlights the diversity and fragmentation of the process literature that examines what makes therapy work. Overt and covert forms of research are highlighted with specific emphasis on the significant events paradigm as the most current exemplar to pursue this investigation. As this domain is fraught with difficulties, criticisms of these developments are also presented leading to the rationale for the research design discussed in chapter two that responds to the thesis question.

Two Strands of Existing Empirical Research: Outcome & Process

Historically, studies that review change determinants are driven by two distinct kinds of research: outcome and process considerations. These aim to explore phenomena within and beyond the therapeutic environment (Bohart, 2000a; Hill & Lambert, 2004). Both these concerns are predominately informed by positivistic ideas that privilege reductionism, deductive reasoning, and theory-testing. Collectively, these goals confirm validity and reliability through the measurement of results and statistical techniques. Nevertheless, despite their popularity, these research thrusts are criticized for their rigidity that aims to minimize error and maintain strict control of a test environment. In this experimental world participants are viewed as scientific tools that operate within the investigative environment. One line of inquiry examines immediate and long-term client changes directly attributable to psychotherapeutic effect. The literature refers to this as the study of outcome effects (Smith & Glass, 1977). Alternatively, process inquiry examines the overt and covert intrapsychic and interpersonal thoughts, feelings, and behaviours of clients and therapists (Hill & Corbett, 1991). As an understanding of both forms of research is essential in reviewing the literature that informs the thesis

question, these constructs are explored extensively throughout this discussion.

With regard to outcomes, McLeod (2003) defines this phenomenon as benefits or changes observable in clients at the completion of a course of treatment. Seligman (1995) contends outcome research comprises the making of evaluative statements about the efficacy or effectiveness of specific interventions. As both efficacy and effectiveness investigations represent positivistic forms of assessment used to evaluate outcome effects, it is helpful to distinguish them (Jacobson & Truax, 1991; Lambert & Ogles, 2004). However, before exploring each of these constructs, it is important to remember that although these methods fulfill an important purpose, they are limited in scope. Essentially they are confined to the scientism of experiments, questionnaires, and coding (McLeod, 1999).

Outcome Enquiry

In an authoritative article Seligman (1995) contends efficacy studies are the “gold standard” (p. 966) of outcome research. This form of inquiry constitutes randomized clinical trials that test experimental therapies by controlling as many variables as possible. Such an approach depends on strict design specifications that privilege internal validity. These controls aim to demonstrate causal relationships between experimental therapy and outcomes by comparing these effects with placebos or no treatment at all. This aims to exclude participants who suffer from co-morbid disorders and incorporates manualized treatments and pre-training of therapists monitored for their adherence to treatment protocols. These parameters are said to ensure uniformity so that other researchers may replicate this investigation. However, although this clear and consistent testing attains high internal validity, it results in poor external validity. Its strict controls are rarely feasible in naturalistic practice so efficacy findings are unlikely to generalize to other circumstances (Fishman, 2000; Mintz, Drake, & Cris-Christoph, 1996; Nathan & Gorman, 2007).

Despite its popularity, considerable problems are inherent in efficacy research that impact on research credibility and applicability. Firstly,

participant and treatment circumstances do not reflect real world clinical practice (Goldfried & Wolfe, 1996; 1998). Approximately, one-third to one-half of the individuals who seek psychotherapeutic treatment do not fall within the criteria of mental disorders outlined by the fourth and current edition of the Diagnostic and Statistical Manual of Mental Disorders commonly referred to as the DSM-IV (Castelnuovo, Faccio, Molinari, Nardone, & Salvini, 2004). Secondly, despite phenotypic similarities, presenting problems are often heterogeneously different in etiology and prognosis (Levant, 2005). Although clients often experience multiple symptoms that are quite diverse, efficacy research fails to account for this differentiation. For instance, although clients who suffer from depression share similar problems, the psychological and situational processes that maintain them often differ substantially. As the ambit of efficacy trials does not consider these circumstances, their results are questionable. Thirdly, as efficacy research fails to take account of therapist/client interpersonal processes, it is difficult to apply its findings to the broader psychotherapeutic domain (Campbell, 2008).

By way of contrast, effectiveness studies focus on the implementation of clinical treatments within naturalistic settings. Individuals who need treatment participate in this form of research regardless of diagnosis or co-morbid psychopathology. Clinical considerations, rather than research design, dictate frequency and duration of treatment. Although assignment to therapeutic intervention may be randomized, efforts to disguise them are rarely feasible. Therapists have limited training in research protocols and generally do not employ manualized treatments. Outcome assessments are defined in terms of change based on degree of disability, quality of life, or shifts in personality rather than targeted evaluations of symptoms (Nathan & Gorman, 2007). Nonetheless, despite these attractions, this form of inquiry is characterized by low internal validity as it is difficult to distinguish individual therapeutic elements and replicate them in other settings. Although outcomes are traditionally measured as changes that occur between pre-therapy and post-therapy markers, researchers consistently argue for more immediate

indexes such as outcomes of specific events or sessions (Greenberg & Pinsof, 1986).

In terms of difficulty, effectiveness studies are less constrained than efficacy research as they focus on external validity rather than internal validity. Generally speaking, clients select choice of treatment without the pressure of exclusion criteria. This maintains the individuality of the therapy experience and the authenticity of the therapeutic setting. Consequently clients who contribute to effectiveness research are said to be less passive than individuals who participate in efficacy trials. As all effectiveness research is non-standardized, efforts to omit scales and operationalize research are increasing. Accordingly, the length and frequency of sessions are variable and multiple pathologies are permitted (Bilsbury & Richman, 2002).

In reflecting on both forms of assessment Barlow (1996) provides succinct definitions of efficacy as “the results of a systematic evaluation of the intervention in a controlled clinical research context” (p. 1051). Accordingly, considerations relevant to the internal validity of conclusions are usually highlighted. This is contrasted with his view of effectiveness studies that examine “applicability and feasibility of the intervention in the local setting where the treatment is delivered” designed to “determine the generalizability of an intervention with established efficacy” (p. 1055). Thus efficacy studies emphasize internal validity and replicability whereas effectiveness studies emphasize external validity and generalizability (Nathan, Stuart, & Dolan, 2000). The other line of empirical inquiry, process research, examines events that occur within sessions and their impact on therapist/client interactions.

Process Research

Process dynamics include overt behaviours of clients and therapists as well as covert thoughts and feelings (Hill & Corbett, 1991). Kiesler (1966) describes this form of exploration as any research investigation that totally, or in part, contains as its data, some direct or indirect measurement of client, therapist, or dyadic behaviour. Typical forms of process research

include content analysis procedures, scales, or questionnaires developed to measure therapist, client, or interactional dimensions.

However, despite the diverse nature of outcome and process research, some studies view increased client satisfaction and motivation as process variables whilst others classify them as outcome effects. Thus the distinction between these diverse forms of research is often blurred (Hill & Corbett, 1993). Nevertheless, most studies determine outcome research comprises the making of evaluative statements about the efficacy or effectiveness of specific interventions. In contrast, process research comprises attempts to explain why improvement or deterioration occurs (Beutler & Hill, 1992).

As knowledge that a particular therapy works together with an understanding of why it is effective informs practitioner decisions about service delivery, both methods pertain to this inquiry (Hill, 1990). Moreover as these diverse forms of outcome and process inquiry contribute to understandings regarding the determinants of psychotherapy, the next task of this discussion reviews each domain in historical context.

Outcome Literature: First Strand of Empirical Inquiry

As psychotherapy gradually emerged as a distinct discipline within the domain of psychological ideas, strong efforts were made to identify its outcome effects. Indeed, a number of objectives supported this endeavour. Primarily efforts were made to establish whether psychotherapy actually worked. Researchers also invested considerable energy in attempting to prove that one brand of psychotherapy is better than others (McLeod, 2003). In addition, research was undertaken to prove that psychotherapy treatments were alternatives to pharmacotherapy intervention (Timulak, 2008). Finally, outcome research was implemented to assess the appropriateness of specific therapeutic modalities for specific problems (Jacobson & Traux, 1991). Outcome research also served the interests of diverse stakeholders who sought to ensure their treatments were empirically valid. Specifically, founders of different theories had a fiscal interest in research that confirmed the legitimacy of their ideas. In

addition, outcome studies provided reassurance that therapy conformed to the dominant ethos of evidence-based practice. Moreover empirical outcome research assured clients their treatments were scientifically valid. Indeed insurance companies and government agencies increasingly looked to outcome research as the principal basis for funding therapies (Bergin & Garfield, 1994; Roth & Fonagy, 1996). The strength of this pattern of development indicated that qualitative inquiry had little place in outcome research (Ponterotto, 2005). Thus this privileging of quantitative methods led McLeod (2003) to contend that measurement before, during and after therapy appeared to be the sole indicator of psychotherapy success. This desire for reassurance is likely to be rooted in the abiding insecurity of researchers and the discipline as a whole that have struggled to prove psychotherapy's legitimacy and right to exist (House, 2003).

Does Psychotherapy Work?

Throughout the twentieth century a contentious issue within the landscape of psychological research turned on the question: does psychotherapy actually work? Scholars debated this issue for decades supported by empirical research that evidenced outcome effects. Although the majority of findings determined that psychotherapy was effective, the informants of these effects remained vague and ambiguous (Bergin, 1971, Lambert & Bergin, 1994, Lambert, Shapiro, & Bergin, 1986, Meltzoff & Kornreich, 1970, Smith, Glass, and Miller, 1980). Research undertaken included controlled studies of large numbers of clients and therapists who applied diverse therapies to a wide range of problems. These assessments employed a wide variety of measures of change to account for both client and therapist responses. Overall the total picture left little room for doubt: psychotherapy was effective because the thrust of all forms of research ascertained clients who received some form of treatment were far better off than individuals who did not. In a recent summary of the outcome literature, Lambert and Ogles (2004) concluded:

Whilst the methods of primary research studies and meta-analytic review can be improved, the pervasive theme of this large body of psychotherapy research remains the same - psychotherapy is

beneficial. This consistent finding across thousands of studies and hundreds of meta-analyses is seemingly undebatable (p.148).

In view of this realization, this discussion begins with a brief overview that traces the history of outcome research. Consequently, this trend is critiqued due to its narrow parameters and lack of in-depth exploration. As this deficit limits knowledge development, the usefulness of qualitative research is demonstrated, highlighting the type of information offered by this mode of inquiry. This position contrasts with the reductionist experimental designs that dominate empirical inquiry. Finally, this discussion calls for the introduction of a pluralistic approach to outcome investigation that incorporates mixed assessment methods. Theorists argue this approach is likely to enrich the scope and depth of outcome studies, making significant contributions to the current zeitgeist of evidence-based health care policies (Cooper & McLeod, 2007).

Historical Development of Outcome Research

Bergin (1971) began his review of outcome research by tracing the earliest studies of the 1920's and 1930's when follow-up investigations were reviewed in clients who benefited from psychoanalysis (Fenichel, 1930). These assessments established psychotherapy caused one third of a clinical population to improve significantly, another third to improve slightly, whilst yet another third remained the same or even deteriorated. Despite these findings, Eysenck (1952) published a forceful critique of these notions drawing on evidence from Landis (1938) and Denker (1946). Eysenck argued individuals who suffered from psychoneurosis and received psychodynamic or insight-oriented interventions displayed the same rate of recovery as individuals who did not have access to these treatments. Thus he claimed psychoanalysis could not be considered effective if it produced the same benefit to clients as no therapy at all. To explain this result Eysenck claimed individuals who experienced an emotional crisis generally underwent a process of 'spontaneous recovery' that led to an increased ability to cope with their problems. Consequently, their difficulties became less severe over time. Hence Eysenck argued individuals inevitably improved

their mental health as they learned to deal with issues that caused emotional disturbance.

Eysenck's (1952) controversial findings had two significant effects that influenced the development of psychotherapy research. Firstly, by the late 1950's his ideas stimulated inquiry into the notion of spontaneous recovery, ushering in the development of experimental designs (Bergin, 1971). Secondly, by the late 1960's, Eysenck's radical views led to the growth of comparative studies with the ability to assess outcome effects of different therapies (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975; Strupp & Howard, 1992). In particular, the introduction of control groups enabled researchers to compare psychotherapy effects with naturally occurring changes in individuals who were not in receipt of therapy. Essentially, these investigations challenged Eysenck's conclusions and determined that psychotherapy contributed substantially to the maintenance of mental health and wellbeing (Bergin, 1971; Luborsky, Singer, & Luborsky, 1975).

Eventually randomized controlled trials became the most popular instrument utilized in the assessment of outcome effects. This trend commenced with the Treatment of Depression Collaborative Research Program (TDCPR) that compared the effects of several psychotherapeutic modalities, pharmacological interventions, and placebos (Elkin, 1994). Trained, supervised members of staff checked adherence and delivery quality of manualized therapies to ensure studies incorporated appropriate statistical power, well-defined client groups, and multiple sensitive instruments to assess therapeutic change. Accordingly, an early outcome study by Sloane et al. (1975) typified this approach by employing a control group to investigate the effectiveness of time-limited psychotherapy with neurotic clients. Its findings established that individuals who seek therapeutic help are likely to gain more from this process than those who simply experience spontaneous remission reviews. Since then, numerous outcome studies have confirmed this early study by establishing unequivocally that psychotherapy causes client change (Lambert et al., 1986; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988). Additionally,

these studies also determined different types of therapy are equally as effective (Luborsky et al., 1975; Roth & Fonagy, 1996; Smith et al., 1980). Moreover Bergin and Lambert (1978) note the data on which Eysenck (1952) based his conclusions may be interpreted many ways. Interestingly, they established that Eysenck's findings determine different percentages based on the criteria selected and method of tabulation applied. Consequently they conclude that Eysenck 'coloured' his results by computing the lowest possible improvement for therapy whilst being as generous as possible in his estimates of spontaneous recovery.

Furthermore, adding to the legitimacy of psychotherapy, Sloane et al. (1975) and less high profile studies (Lambert et al., 1986; Luborsky et al., 1988) were increasingly validated by numerous sophisticated research summaries coined meta-analyses. These are mathematical instruments utilized to measure the size and percentage of treatment effects based on large amounts of research data. These innovative devices verified that approximately sixty-five per cent of clients sustained improvements as a result of psychotherapy (Andrews & Harvey, 1981; Shapiro & Shapiro, 1982; Smith & Glass, 1977). Smith et al. (1980), the first meta-analytic study to assess outcome effects, also examined numerous factors that influence these conclusions. This confirmed the average effect size in comparison to control groups across different measures and client groups is 0.85. The size of effect indicated that a person in a treatment group who is at the fiftieth percentile would improve to the equivalent of the eightieth percentile of the control group. Similarly, Lambert et al., and Howard, Kopta, Krause, and Orlinsky (1986) suggested an improvement rate of at least seventy per cent of treated clients compared with a forty per cent improvement rate for untreated clients. Thus these sophisticated evaluations concluded that psychotherapy was effective in facilitating change at faster, more substantial rates than healing processes and supportive elements within the natural environment (Lambert & Bergin, 1992). However acceptance of this form of research has been mixed. In a seminal review, Roth and Fonagy (1996) conclude that randomized controlled trials, as the basis of meta-analyses, are the "gold standard of outcome research and the only reliable

evidence that may be viewed as valid and true" (p. 19). However Bohart and House (2008) refute this approach, asserting the randomized controlled trial represents "a glaring example of the colonizing hegemony of a positivistic, control-oriented hegemony which assumes its one-size fit-all methodologies to be universally applicable to all dimensions of reality (p. 192).

Furthermore, in a comprehensive and insightful critique of randomized control trials McLeod (2001) asserts Roth and Fonagy (1996) overlook the role of qualitative research in outcome research. Specifically McLeod charges they make no mention of the contribution of qualitative evaluative studies, clinical case studies, naturalistic research, user satisfaction surveys, and professional consensus judgments. Accordingly, some discussion of these deficits articulated by McLeod is necessary to conclude this review of outcome effects.

Criticisms of Outcome Research

McLeod (2001) asserts randomized controlled trial (RCT) methodology is open to a series of compelling challenges that Hemmings (2008) posit are unsatisfactorily refuted. Bohart and House (2008) also claim such objections "constitute a devastating 'case against' the embracing of RCT methodology in psychotherapeutic research" (p.192). Firstly, McLeod, Bohart and House, and other like-minded critics assert that RCT methodology hides what happens to individuals during a research trial. Thus individuals in control and non-control groups may be worse off after exposure to 'treatment' although this position may never be disclosed. Secondly, RCT procedures are said to ignore different responses of different individuals to the same treatment. Thirdly, RCT outcomes are attacked for their ongoing failure to acknowledge the phenomenon of self-healing and the role of the mind in recovery. Fourthly, RCT tenets are criticized for their assumption that the validity of their univariate approach has the capacity to separate out single treatment variables from all other influences to assess causal impact. Fifthly, it is argued that RCT notions objectify human suffering and reify external causal influences that ignore subjective illness experienced by clients. Finally, the assumptions that underpin RCT are criticized for

ignoring their so-called statements of 'fact' are actually value-laden theories formulated within a pre-existing set of subjective hypotheses.

Apart from these technical issues McLeod (2001) also objects to randomized control trials from a philosophical stance asserting these devices exclude the voice of research participants. Indeed, McLeod contends this omission prevents exploration of client feelings concerning their therapy as well as researcher judgments about its implementation. Thus reflexivity by both member groups is prevented. McLeod also posits these methods reinforce the medicalization of therapy through their focus on assessment, diagnostic measures, and randomization. Significantly, McLeod makes the point that implementation of these strategies is consistent with the view that clients are mere passive recipients of treatments commensurate with the human response to the administration of drugs. McLeod also stresses this form of psychotherapeutic research is elitist and discriminatory. The expense and complexity of these trials suggest they are confined to exclusive institutions that are funded appropriately so they have the capacity to support such endeavours. Moreover, this type of research rarely focuses on more marginalized therapies such as feminist, transpersonal, and multicultural therapies. McLeod also concludes that ethical considerations implicit in the no-treatment waiting lists or placebo groups of randomized controlled trials are rarely addressed. In addition, McLeod postulates the implementation of therapy in the real-world is characterised by lengthy treatment periods and high client attrition rates. Accordingly these naturalistic conditions are generally compromised in terms of finances by randomized controlled trials that subject clients to fixed, limited numbers of sessions to reduce costs. Finally, Schmitt Freire (2006) postulates that these methodological concepts and values drawn from experimental science exclude contextual social, cultural, and political phenomena. Accordingly, their results have limited legitimacy when applied to real-world populations.

Nevertheless, in spite of these deficits it cannot be denied that the promotion of randomized controlled trials enhances the status and economic power of existing elite groups that operate within the domain of

psychotherapy (McLeod, 2001). Indeed, this conceptualisation fosters support for the medical model that views assessment, diagnosis, and application of specific therapies as appropriate. Moreover this stance legitimizes the responses of detached clinical 'experts' who measure results using standardized technologies. Additionally, it ignores client preferences, individualization, and advances the medicalization of social problems. To counter these techne deficiencies various critiques protest that alternative research paradigms be adopted. Accordingly, as this recommendation underpins the design of this study, these ideas are explored as the next objective of this discussion.

Qualitative Outcome Studies: An Alternative Paradigm

Discovery oriented research represents the main alternative to traditional forms of technified outcome research. Indeed, McLeod (2001) recommends that the effects of psychotherapy are more accurately assessed through the lens of rich qualitative data. Yet this approach is rarely employed due to the techne mind-set of psychotherapy that equates evaluation of effective outcomes with the application of measures. Indeed, Morrow (2007) contends that although researchers like Elliott (1984) and Rennie (1994) apply qualitative approaches "to formalize the methods of qualitative research into therapy" (McLeod, 2001, p. 10) this does not extend to outcome review. However, despite this reticence, numerous studies enacted in recent decades demonstrate the effectiveness of qualitative strategies in overcoming the limitations of traditional research procedures (Kuhnlein, 1999; McKenna & Todd, 1997). Indeed, McLeod (2001) posits quantitative assessment often obscures the true nature of therapy outcomes by presenting a limited picture of how clients use therapy to change their lives. Nevertheless, although Howard (1983), Mearns (1997), and Cooper (2008) make pleas for methodological pluralism within psychotherapy, this appears to have little impact. Although there are recent additions to these exemplars (Daniel & McLeod, 2006; Levitt, Butler, & Hill, 2006) qualitative outcome research within psychotherapy remains limited. Indeed McLeod (2001) playfully contends that when there are four hundred and eighty qualitative outcome studies (the number of controlled trials

reviewed in the meta-analysis of Smith et al., (1980) “we will be in a better position to judge the contribution of this approach” (p. 180).

Having examined psychotherapeutic efficacy and effectiveness in the context of enhanced outcome effects this discussion turns its attention to an overview of the second strand of empirical research – process investigation. Although this method of inquiry is principally informed by a positivistic ethos, it incorporates a more pluralistic stance that includes both quantitative and qualitative notions.

Process Research: Second Strand of Empirical Inquiry

Although outcome research confirms that psychotherapy works, process research seeks to uncover how it works (Kiesler, 1983). However, in addressing this question, researchers find it difficult to maintain consistent understandings of the meaning of process as a concept, per se (Elliott, 1991). For instance, McLeod, (2003) views process as a general condition that exists within the therapeutic encounter, stressing the actual interactions of client and therapist are process dynamics. Additionally, Kiesler and Strupp (2006, p. 107) assert process studies deal with therapist/client interactions. Thus this type of investigation usually centers on the interchange between these parties. Kiesler and Strupp contend process research refers to any investigation that totally, or in part, “contains as its data, some direct or indirect assessment of client, therapist or dyadic behaviour within the therapy interview” (p.2). Alternatively, a working definition articulated by Hill and Corbett (1993) has substantial support. This posits process research constitutes a method of examining overt, observable behaviour and covert thoughts and feelings of clients and therapists that manifest in their interpersonal contact within the psychotherapeutic session. Orlinsky, Rønnestad, and Willutzki (2003), leading scholars in the field, define therapeutic process as “the actions, experiences and relatedness of clients and therapists when they are physically together” (p. 311). This statement envisages process research includes individual perceptions, intentions, thoughts, and feelings of therapy participants in the context of their interpersonal relationship that takes place within therapeutic sessions (Elliott, 1984; Hill, 1986). Hence

these varied definitional notions reveal the broad scope of this realm of inquiry. Accordingly, this critique presents a brief overview of the historical developments of the field that reflects this diversity

Historical Development of Process Research

Rogers's (1942) use of tape recordings to study therapeutic process represents a seminal development as it facilitated scientific scrutiny of covert and overt events within the therapeutic encounter. The 1950's and 1960's saw the development of instruments such as expert-rated scales (Greenberg & Pinsof, 1986), the Barrett-Lennard Relationship Inventory (1964), and the Therapy Session Reports (Orlinsky & Howard, 1966). These developments enabled the perspectives of both client and therapist to be captured through quantitative assessment. As most of this research conducted from the 1940s to the 1960s, were based on Roger's (1942) client centered theory, these studies focused on client experiencing. However by the 1950s the Menninger Foundation in the United States began to research process and outcome in the context of psychoanalysis (Wallerstein, 1992). These efforts were continued by Luborsky in the 1960's who studied the effect of transference on the therapeutic alliance. Specifically, Luborsky, Crits-Christoph, and Mellon (1986) developed a measure to assess the impact of transference, coined the Core Conflictual Relationship Theme (CCRT). This provided the first concrete evidence that authenticated Freud's transference and counter-transference ideas (Luborsky, Graff, Pulver, & Curtis, 1973).

By the 1980's new forms of inquiry emerged that studied therapeutic process through the lens of diverse stages of development. This approach, championed by Rice and Greenberg (1984), reviewed successive, incremental progress in process development. The 1980s also witnessed sophisticated studies by the Mount Zion Psychotherapeutic Group (Weiss & Sampson, 1986) that predicted therapeutic process in long-term psychoanalytic therapy. In this period technological development in video also enabled clients and therapists to comment on therapeutic processes immediately after sessions in a new form of assessment termed Interpersonal Process Recall (Elliott, 1986). The 1980s was also

characterised by a huge growth in process-outcome studies directed by Orlinsky, Grawe, and Parks (1994). These researchers identified one hundred and ninety two studies between 1985 and 1992 that examined the relationship between process variables and outcomes. Altogether, these studies determined that twelve hundred independent findings linked some aspect of therapeutic process to therapy outcome. The 1990's highlighted qualitative methodologies and their contribution to the research of psychotherapeutic process. This introduced a more flexible approach to investigating the complexity of this domain. Clients and therapists who participated in sessions were invited to comment on their experience (Rennie, 1990). Studies that focused on the process of successful or unsuccessful therapy also flourished in this period (Honos-Webb, Stiles, Greenberg, & Goldman, 1998).

This historical overview provides a brief glimpse of the complexity of analyzing therapeutic process. Therapists are required to untangle multiple simultaneous events that emerge in sessions from both cognitive and affective perspectives. This necessitates examination of behaviours, feelings, and actions at an intrapsychic and interpersonal level. As McLeod (1999) suggests, this involves an ethically sensitive journey into the "interior of therapy" (p. 31). In view of this challenge researchers use a variety of methods to investigate the domain. As these strategies are somewhat idiosyncratic and aim at specific therapeutic circumstances, they are classified into quantitative and qualitative categories. However, unlike outcome research, quantitative and qualitative inquiry is well represented in process exploration. Accordingly, the next task of this review explores each of these means of investigation.

Quantitative Process Studies

Researchers seeking to quantify the process of therapy implement two kinds of methods to capture this data. One approach records sessions by audio or video-tape and analyses these at a later point in time from the recordings and written transcripts. The early work of Rogers (1942) and Gendlin and Tomlinson (1967) initiated this method in the context of client centred therapy. Moreover, Luborsky, McLellan, Woody, O'Brien, and

Auerbach (1985) continued this approach in psychoanalytic research that analyzed transference dynamics from transcripts of therapy sessions. An alternative technique invited clients and therapists to complete questionnaires at the end of sessions. Although this was an easy way to gather data, it relied on the capacity of client and therapist to remember the events of a session. As levels of process variables such as empathy vary dramatically within single sessions, client ratings over a whole session were often misleading. Nevertheless, despite these limitations, session ratings and post-session questionnaires were considered to yield important insights into the process of psychotherapy.

Qualitative Process Studies

Although quantitative methods represent the dominant investigative thrust in empirical process research, qualitative research is also strongly represented. This is useful as it overcomes some of the shortfalls of quantitative assessment that fails to capture the complexity of moment-to-moment changes in the therapeutic environment. In particular, qualitative inquiry has the capacity to address the covert nature of events. Client and therapist immersion in the therapeutic process means participants are unaware of important unconscious processes that take place. Thus a new generation of process research attempts to develop techniques to open up this realm. Four main approaches have emerged. These include narrative and discourse analysis, post-session interviews, open-ended written questionnaires, and Interpersonal Process Recall (Timulak, 2008). Narrative and discourse analysis requires researchers to work qualitatively with transcripts of sessions rather than depend on quantitative approaches that impose researcher-defined coding schemes. Specifically, qualitative inquiry looks at language use in open ways to discern interpersonal and intrapsychic dynamics within sessions. For example, in the case of narrative analysis, McLeod and Balamoutsou (1996) study the process of language use by a client from a statement that describes reasons for seeking psychotherapy. In a discourse analysis Davis (1986) evaluates the transcript of a session in which a therapist re-defines a client's description of their problems. Post-session interviews are widely used to discuss client or therapist experience

(Maluccio, 1979) and are often implemented in conjunction with open-ended post-session questionnaires. These are written accounts of client or therapist experience regarding their perceptions of different therapeutic processes (Hill, Nutt-Williams, Heaton, Thompson, & Rhode 1996). Despite the richness of both methods, client/therapist dependence on memory represents a fundamental flaw with the potential to create anomalies. However, Elliott's (1986) Interpersonal Process Recall technique resolves this problem that involves the taping of psychotherapy sessions and then playing them back to clients and/or therapists within twenty four hours of sessions. This is regarded as a productive way to gain rich material of conscious and unconscious processes as well as tacit knowledge, thoughts, and feelings.

Having completed a generalized critique of outcome and process research that examines how psychotherapy works the next stage of this discussion refers to specific controversies raised by this question. Within the realm of outcome research, this issue falls within the ambit of two disparate theoretical camps referred to earlier in this chapter as specific and common factors. Accordingly, these lines of research engender a polarized debate that has occupied the minds of researchers for more than four decades. In view of its significance, this commentary turns its attention to this discourse as a central feature of this literature review.

Specific & Common Factors in Outcome Literature

One line of research within the outcomes literature favours specific factors, unique to particular brands of psychotherapeutic treatment, as the active ingredients of outcome changes. Although this approach incorporates diverse understandings of the nature and origin of client problems, Garfield (1995) contends these explanations are not curative in themselves. Alternatively, he posits the actual "provision of a rationale that explains the patient's problem is the important variable (p. 128)". Essentially, Garfield contends the curative effects of psychotherapy are activated by the actual process of providing clients with an understanding of their difficulties. Accordingly, this view rejects precise explanations offered by different therapies claiming that specific features of modality are primarily

responsible for outcome effects. Consequently, factors common to all therapies are most likely to embody operant change agents (Sloane et al., 1975). Essentially this position affirms empirical evidence that validates the effectiveness of psychotherapy but does not suggest that specific treatments are superior to others (Lambert et al., 1986; Luborsky et al., 1975; Smith et al., 1980; Stiles, Shapiro, & Elliott, 1986). Indeed, Asay and Lambert (1999) observe that:

For those convinced of the singular abilities of their models and related interventions, the results have been disappointing, as there is little or no difference between therapies and techniques (p. 39-40)

Nevertheless, despite these conclusions, a variety of commentators (Norcross & Goldfried, 2005, p. 3) contend that an “ideological cold war” has arisen between competing modalities that smacks of “theoretical narcissism” (Norcross (1999, p. xviii). Indeed Hubble, Duncan, & Miller (1999) charge this “battle of the brands (p. 5)” embodies a spirited debate that privileges the dominance of certain therapies over others. Although the empirical evidence that supports this stance is limited, it is helpful to consider the effect of specific factors on client outcomes.

Specific Factors: Battle of the Brands

The last quarter of the twentieth century witnessed frequent attempts to prove the effectiveness of psychotherapy (Elkin et al., 1989; Sloane et al., 1975). Consequently, during this period, the number of therapy models grew from sixty to more than four hundred (Tallman & Bohart, 1999). Although a variety of factors influenced this trend, Bergin and Lambert’s (1978) reasons are most persuasive. They argue this movement was driven by the methodological limitations of early research that renders conclusions based on these studies suspect. In pursuit of clarifying these developments, Bergin and Lambert posit researchers with vested interests ushered in an era of clinical trials in outcome research (Duncan, 2002). These efforts aimed to prove that specific brands of therapy were the “magic bullet in the psychotherapy revolver (Duncan et

al., 2004, p. 31)". Consequently an empirical "cross fire" (Fonagy, 2001, p. 647) saw major treatments for psychological distress "pitted against each other in a great battle of the brands (Duncan, p. 42)". As Bergin and Lambert contend, this contest actively sought winners and losers. Yet, despite this hubris, the critical mass of data revealed little overall difference in treatment effectiveness (Hubble, Duncan, & Miller, 1999; Norcross and Newman, 1992). Finally, a pronouncement by Luborsky et al., (1975) based on Lewis Carroll's verdict of the dodo bird from *Alice in Wonderland*, sought to end this "bonfire of the vanities" (Hubble et al., p.6). Accordingly, this landmark statement claimed that "everyone has won so all must have prizes (p. 995)" within the domain of outcome research. In effect, this view concluded, unequivocally, that specific factors in diverse therapeutic modalities have a comparable effect on client outcomes (Luborsky et al., 1975).

Thus, this declaration by Luborsky et al. (1975) re-ignited support for Rosenzweig's (1936) dodo bird hypothesis. This latter claimed that theoretical commonalities, present in all therapeutic frameworks, inform positive outcomes in psychotherapy. Although Rosenzweig stressed this view by quoting the dodo bird verdict in the sub-title of his publication, his ideas were initially overlooked. However, when Luborsky et al., cited Rosenzweig's verdict to illustrate that all brands of therapies have a similar effect on outcomes, it captured the attention of the psychotherapeutic community. Indeed Rosenzweig's (1936) comments set the stage for a series of meta-analyses that validate the notion that therapeutic treatments, with some exceptions, are uniformly effective (Elkin, 1994; Lambert & Bergin, 1992; Wampold et al., 1997).

Nevertheless, despite this development, Asay and Lambert (1999) point out that "the findings of no difference went unheeded" (p. 40). Moreover Fishman (1999) argues that as over eighty per cent of research remains devoted to privileging specific techniques, "enthusiasm for researching the effects of specific schools or interventions" (p. 39) continues unabated. Even though the "bells and whistles" (Hubble et al., 1999, p.6) of competing treatments make little difference to client

outcomes, researchers persist in examining their effects to discover the causes of therapeutic success. However, it is suggested that the cumulative efforts of researchers like Duncan et al. (2004) and Duncan, Miller, Wampold, & Hubble (2009) have finally stemmed this tide. Indeed, their aim to break the tradition of claiming 'mine is better than yours' has slowed this trend. Specifically, their pantheoretical approach favours a combination of empirical evidence-based and practice-based research that identifies common factors that impact on effectiveness (Bohart & Tallman, 1996). Thus, over time, the significance of common factors with regard to effectiveness has advanced so that finally, most dimensions of the therapeutic setting are increasingly examined by researchers (Lambert & Bergin, 1994).

This developing research thrust is in keeping with a large quantitative review by Wampold (2001) that ascertains seventy per cent of psychotherapy effects stem from common factors whilst only eight per cent at most, are a result of specific ingredients (Imel & Wampold, 2008). Thus a historical review that traces the gradual development of these important elements reveals their inherent nature and mode of operation.

What Are Common Factors?

Although a large body of research investigates the role of common factors in all types of psychotherapy (Asay & Lambert, 1999) these elements have gained increased significance in the last two decades as the mental health profession sought to identify the informants of client change (Garfield, 1992; Bergin & Garfield, 1994; Lambert, 1992; Lambert & Bergin, 1994). Indeed Norcross (1999) contends this trend aims to determine core ingredients shared by different therapies with "the goal of creating more parsimonious and efficacious treatments based on these commonalities" (p. xviii). A brief historical review of the emergence of these factors signifies their importance.

History of Common Factors

There is general agreement that Rosenzweig's (1936) dodo bird verdict represents the first attempt to identify common factors from an

empirical perspective. Indeed, Luborsky (1995) contends that Rosenzweig's historic verdict deserves a laurel "as the first systematic presentation of the idea that common factors across diverse forms of psychotherapy are so omnipresent that comparative studies should show non-significant differences in outcomes" (p. 106). Although Rosenzweig's synthesis was overlooked for some time, Frank (1961, 1973) re-energized his conceptualisation by identifying four features that characterize all forms of effective psychotherapy. In reflecting on this explication, Frank and Frank (1991) identify these elements as: an emotionally charged, confiding relationship with a helping person; a healing setting; a rationale conceptual scheme or myth that provides a plausible explanation for the patient's symptoms and proscribes a ritual or procedure for resolving them and a ritual or procedure that requires the active participation of both patient and therapist that is believed by both to be the means of restoring the patient's health.

Eventually Lambert (1986) added strength to Frank's (1961, 1973) ideas by empirically establishing four distinct influences advance client development in the realm of psychotherapy. Specifically, Lambert (1986) classified these determinants into four distinct categories coined 'non-specific' factors. These include:

- i. Extratherapeutic influences;
- ii. Client/therapist relational features;
- iii. Placebo, hope and expectancy effects and
- iv. Model and technique influences.

Although much of the early outcome literature refers to all four categories as non-specific factors, in a series of articles and investigations Miller, Duncan, & Hubble, (1997) and Hubble et al., (1999) adopt the nomenclature of common factors to describe these constructs. As these theorists are considered leading exponents of the empirical evidence on outcome effects, this notion has attained general acceptance in the psychotherapeutic community.

In his early studies Lambert (1986) also quantified the impact of each of these categories on client change. This assessment confirms that forty per cent of outcome effects are attributable to client extratherapeutic factors; thirty per cent of client change stems from client/therapist relational factors; fifteen per cent of outcome effects may be attributed to placebos and expectancies, and another fifteen per cent emanate from model and technique factors (Bachelor & Horvath, 1999; Ogles et al., 1999). As these categories are viewed as important informants of client outcomes, they are individually described in the ensuing discussion.

Client Factors

Extratherapeutic factors comprise elements clients bring to therapy that contribute to their healing independently of therapy participation (Bergin & Lambert, 1978). This class of features, identified as the most influential common factor, includes client personal characteristics such as inner strengths, religious faith, goal directedness, agency and motivation as well as attributes beyond client control such as fortuitous events and social supports. In short, these qualities encompass influences that clients bring to the therapeutic encounter as well as pressures exerted on them in their lives outside therapy (Tallman & Bohart, 1999). Recent reviews highlight the importance of these features by asserting clients are the “engine that makes therapy work” (Tallman & Bohart, 1999, p. 91). Furthermore Miller et al. (1997) posit “the research literature makes it clear that the client is actually the single, most potent contributor to outcome” (pp. 25-26). Indeed, some theorists contend psychotherapy facilitates naturally occurring healing in people’s lives. Thus this approach espouses therapists function as mere support systems and resource-providers to clients who shape the landscape of their lives.

Notwithstanding the merits of this approach, these views are at odds with most positivistic literature that portrays therapists as heroes armed with “potent techniques and procedures that intervene in people’s lives and fix their malfunctioning machinery” (Tallman & Bohart, 1999, p. 91). This realist perspective emphasizes efforts, theories, and technical mastery of all-powerful therapists, perceived as the primary instigators of therapeutic

change. From this perspective, client contributions are marginalized by a reductionist paradigm that depicts clients as disempowered individuals who suffer from poor insight, weak ego structures, entrenched defensive structures, and personality disorganization.

To counter this stance Tallman and Bohart (1999) assert potential client gain from therapist offerings constitutes the most influential informant of effective psychotherapy. In particular, they argue the capacity of clients to tailor therapy experiences to suit individual needs empowers them to resolve their difficulties. In short, the strength of extratherapeutic factors is prefaced on the capacity of clients to implement strategies based on influences they encounter in their lives. Thus clients do much more than simply rely passively on pre-determined aims. Contrarily, clients are viewed as 'magicians' with special healing powers that crystallize as therapists morph into assistants that foster appropriate conditions that facilitate the operation of magic (Bohart, 2000b). As "client variables and extratherapeutic events and their relation to outcome could fill a volume (Hubble et al., 1999, p. 30)" a full discussion of these features is beyond the scope of this review. However as forty per cent of outcome effects are attributed to client features, a brief snapshot of their empirical contribution constitutes the next stage of this discussion. Although quantitative investigation characterizes much of this inquiry, this review also includes some of the qualitative efforts that enhance this knowledge domain.

Quantitative Research on Client Factors

Much of the early empirical research that outlines the importance of extratherapeutic factors is summarized by Garfield, (1976). He suggests some extratherapeutic factors such as client motivation are rapidly affected through the application of psychotherapy whilst other features such as personality style are more resistant to change. The empirical importance of extratherapeutic factors is highlighted well in a case studies reported by Strupp (1980a). Although all therapists who participated in this study demonstrate good interpersonal skills, each therapist develops a different relationship with each client. Clients who achieve better outcomes are

more willing to develop better relationships with therapists whilst clients who achieve poor outcomes do not relate well to their therapists and maintain superficial connections with them. As Strupp's analysis determines that therapist contributions remain stable throughout the course of the therapy, the difference in outcome is deemed to stem from extratherapeutic factors such as client psychological make-up, maturity, and motivation.

Much of the quantitative research into extratherapeutic factors suggests that client improvement occurs more rapidly when clients believe these changes derive primarily from their own efforts (Garfield, 1994). For instance, Phillips (1984) finds that clients exposed to a variety of therapeutic approaches report that the most healing aspect of their treatment emanates from their decisions to work on their problems. Moreover Elliott (1984) ascertains that clients who are active in selecting out what they want from their therapists become increasingly proficient in stimulating therapist interpretative statements that dispose of tangential material. Orlinsky, Grawe, and Parks (1994) also conclude that co-operative and open clients are more willing to participate in therapeutic encounters. Consequently they are more likely to benefit from experiences that generate effective therapeutic treatments. These theorists also suggest that the quality of client participation in therapy "stands out as the most important determinant of outcome (p. 361). Moreover, in a Consumer Reports Study, Seligman (1995) establishes that clients who report being actively involved in the process of psychotherapy benefit most from this experience.

Other evidence from the literature on spontaneous remission posits that a large proportion of clients improve without formal psychotherapeutic intervention (Bergin & Lambert, 1978; Lambert & Bergin, 1994). These studies include participants in receipt of minimal treatment, untreated individuals, and non-extensive psychotherapy. The median rate of extratherapeutic treatment is forty-three per cent with a range from eighteen to sixty seven per cent. These findings highlight the importance of supportive aspects of the natural environment of clients. Features

considered significant include self-help literature and self-help groups (Ogles, Lambert, & Craig, 1991).

Qualitative Research on Client Factors

Although most research that examines the impact of clients on outcome success reflects quantitative concerns, qualitative studies also evaluate this common factor. For instance, Rennie (2000) demonstrates that clients are highly active participants in psychotherapy who do far more than merely receive therapist input. Rennie reveals clients think about therapist input, draw their own inferences from this encounter, and subtly arrange and manipulate sessions to get their needs met. In an early study Rennie (1992) identifies this capacity as “client reflexivity, a quality of self-awareness and self-control” (p. 224). A qualitative study by Winefield, Chandler, and Bassett (1989) researches the use of tag questions by clients, their impact on client experience of psychotherapy and how these devices affected their conversational efficacy. The study establishes that increased use of tag questions by female clients correlates with increasing independence in therapy. Indeed Maione and Chenail (1999) assert this study provides clear evidence that clients, through their conversational patterns, shape the way therapists participate in the therapeutic encounter. Although these commentators make the point that qualitative investigations of extratherapeutic factors are “sparse” (p. 63), there is ample evidence that clients function as active agents of influence in the therapeutic process. Indeed Bergin and Garfield (1994) conclude:

It is the client more than the therapist who implements the change process. If the client does not absorb, utilize, and follow through on the facilitative efforts of the therapist, then nothing happens. Rather than argue over whether or not ‘therapy works,’ we could address ourselves to the question of whether or not ‘the client works’! In this regard, there needs to be a reform in our thinking about the efficacy of psychotherapy. Clients are not inert objects upon whom techniques are administered. They are not dependent variables upon whom independent variables operate...As therapists

have depended more upon the client's resources, more change seems to occur (pp. 825-826).

As indicated previously relationship issues constitute the second most influential common factor, accounting for thirty per cent of outcome effect. Consequently, this commentary provides a brief introduction to this construct in the context of outcome research (Wampold, 2001).

Relationship Factors

The therapeutic relationship, more than any other factor, has caught the attention of informed commentary. As indicated, Lambert (1986) considers thirty per cent of client change stems from client/therapist relational factors. Clinicians and researchers alike acknowledge the central role of this construct in the process of psychotherapy change (Gelso & Carter, 1985). As this factor and its outcome effects are the subject of extensive informed commentary and research, a full discussion of this construct is beyond the parameters of this thesis. Consequently, this discussion presents a brief review of the meaning of this notion, describing how it is investigated in the context of quantitative and qualitative research.

Freud (1912) is identified as the first clinician to comment on three aspects of the relationship that have a profound effect on client outcomes. These include: i) the transference relationship that emanates from the unconscious identification of the therapist with significant figures from the past by clients; ii) the countertransference relationship that emerges from the unconscious linking of the client with significant figures or unresolved conflicts from the past by therapists and iii) the linking by clients of the therapist with benevolent and positive personae's from the past. The latter aspect, subsequently named the working alliance is the focus of development and elaboration by a number of theorists (Greenson, 1965). Accordingly, Freud's analytic conceptualisation of the therapeutic relationship was dominant until Rogers (1957) presents a significantly different perspective. Rogers (1957) constructs the ideal therapeutic relationship as a form of existential encounter rather than a meeting

between an expert and acolyte. Moreover, he identifies a number of facilitative conditions led by therapists with the potential to activate innate client healing and growth.

However, the next development in the growing importance of the therapeutic relationship, shifts inquiry from the qualities of therapists to client beliefs with regard to therapist trustworthiness. Thus this development positions the therapeutic relationship and its effects into a framework of social influences (Strong, 1968) that advances the assumption that therapists have the power to influence clients as a result of their expertise, integrity and credibility. Consequently, a variety of views emerge with competing views regarding the nature and effect of the therapeutic relationship. However, a series of studies that examine the impact of this construct on client change conclude outcome effects of relationship rarely vary and are independent of therapeutic framework (Heppner, Rosenberg, & Hedgespeth, 1992). In a more recent trend, Bohart (2000a) suggests a strong therapeutic relationship encourages client involvement. Thus clients who experience warm and empathic relationships with therapists are more likely to view therapy as a safe space to take risks and learn. Moreover Bachelor and Horvath (1999) argue when clients feel seen and understood they are more likely to invest themselves in the therapeutic process. Indeed, empirical evidence suggests that if client and therapist develop a strong therapeutic relationship early in their contact, this is the best predictor of outcome success. This position is compatible with the notion that engagement qualities of the therapeutic relationship together with therapist personal qualities are more significant influences on outcome effects than therapist training or experience. Specifically, therapist capacity to engage with clients and offer hope is perceived to be more important than professional expertise (Bachelor & Horvath, 1999; Luborsky et al., 1985).

Moreover, in accord with the views of Rosenzweig (1936) and Frank and Frank (1991), researchers increasingly recognize relational attributes within the therapeutic relationship function as important determinates of outcome effects. Firstly, many schools of thought assert the therapeutic

alliance or working alliance constitutes an important informant of outcome effects. Secondly, according to Orlinsky (1999), empathic resonance and mutual affirmation are essential ingredients of the therapeutic relationship. Thirdly, Gelso and Carter (1985, 1994) insist the therapeutic relationship is also characterized by a 'real relationship' that incorporates the realistic, undistorted perceptions and reactions of participants as well as a transference relationship. The latter refers to the repetition of past relationship issues, conflicts and feelings that are played out by clients on their therapist (Greenberg, 1994; Hill, 1994). However some authors take issue with the notion of a real relationship on epistemological grounds. Consequently, they debate the relevance of past issues triggered in the here and now of therapy (Strupp, 1973). Dynamically oriented therapists tend to view these issues as critically important whereas others review them as minimally significant (Watson & Greenberg, 1994). Finally, Roger's (1952) core conditions are also important dynamics within the therapeutic relationship that impact on outcome variance. Additionally empirical studies that demonstrate unequivocal support for the nexus between relationship issues and outcomes are well documented. Quantitative research consistently determines the quality of the client/therapist relationship has a critical impact on client effects.

Quantitative Research on Relationship Factors

Much of the initial research on relationship factors and outcome effects emerges from Roger's (1957) client centred tradition. This espouses that a number of "necessary and sufficient conditions" foster client change (p. 95). These core conditions are conceptualized as empathy, positive regard, non-possessive warmth, genuineness, and congruence (Horvath, 1994). Although most therapeutic frameworks incorporate these qualities as desirable therapist attributions, they are more accurately viewed as examples of interpersonal dynamics (Asay & Lambert, 1999). Accordingly, these qualities are explored later as aspects of therapeutic process as this section of this review is confined to a précis of the empirical literature that examines the therapeutic relationship as a common factor that affects client outcomes. Nevertheless, as Gelso and Carter (1994) point out,

although this element is considered a powerful influence on client outcomes “little effort has been made to define just what the relationship is” (p. 296). Thus Gelso and Carter propose the therapeutic relationship be perceived as the “feelings, attitudes that counselling participants have toward one another, and the manner in which these are expressed” (p. 159). However, other writers prefer to restrict the meaning of this concept to the feelings of individuals as distinct from their actions and behaviours (Hill, 1994). Alternatively, theorists insist facilitative conditions that drive the therapeutic relationship best describe its meaning (Orlinsky & Howard, 1987). Nonetheless, despite this lack of clarity, there is general agreement that the working alliance and its emphasis on client/therapist collaboration is an integral feature of the therapeutic relationship.

Studies that demonstrate the link between therapist attributes and positive client outcomes are unequivocal in their findings (Gurman, 1977). They reveal a strong correlation between therapist skills and positive client effects (Miller, Taylor, & West, 1980). Indeed, major reviews indicate the significant influence of the therapeutic relationship on outcome effects in a variety of therapeutic contexts (Horvath & Symonds, 1991; Luborsky, Crits-Christoph, Minz, & Auerbach, 1988; Orlinsky & Howard, 1986). In particular, the literature distinguishes the therapeutic alliance as an active factor in the success of therapy (Lambert & Bergen, 1994).

The Therapeutic Alliance

This notion was first described by Freud (1912) who stressed the importance of the analysand’s attachment to the psychoanalyst and their reciprocal interest in understanding the analysand in the early stages of therapy. Over time the therapeutic alliance has been reviewed and revised by numerous researchers including Bowlby (1988) and Greenson (1965). Although a detailed analysis of this construct is beyond the scope of this commentary, some attempt to describe its importance in terms of the empirical literature is offered.

Bordin’s (1979) highlights three important features of the therapeutic alliance: namely, its task, bonds, and goals. Tasks are the actual

behaviours that represent the actual work of therapy. Bordin stresses when both therapist and client privilege these elements, it ensures development of a strong therapeutic alliance. The goals of therapy constitute the client/therapist agreed-upon task that is endorsed and valued by both parties. Bonds embody close interpersonal attachments of trust, confidence, and acceptance (Asay & Lambert, 1999, p. 35). Moreover as Bordin contends, all three aspects constitute the alliance, he asserts this construct is healing in itself. In a slightly different conceptualisation, Luborsky (1976) proposes a number of distinct features characterize the alliance. These include mutual liking, therapist perceived support, and shared responsibilities. When these join together Luborsky claims the alliance becomes the "glue" that binds the therapist to the client yet is not, in itself, therapeutic (Asay & Lambert, 1999, p. 136). In an attempt to integrate these efforts, Gaston (1990) suggests the nexus between the alliance and client outcomes are evidenced empirically in a number of ways. Specifically, Gaston contends certain features of the therapeutic alliance are measurable in terms of their influence on the end-result on therapy. These include: i) client affective connection and its therapeutic impact; ii) client capacity to work purposefully; iii) therapist empathic understanding and involvement and iv) client and therapist agreement on the goals and tasks of therapy.

Most of the empirical work regarding the therapeutic alliance has been generated by psychodynamic researchers (Horvath & Greenberg, 1994; Horvath & Luborsky, 1993) although its influence has spread to domains like behaviour therapy (DeRubeis & Feeley, 1990) and cognitive therapy (Krupnick, Sotsky, Simmens, Moyer, Elkin, Walkins, & Pilkonis, 1996). Furthermore, the strength of the alliance and its impact on outcomes is frequently measured by client, therapist, and independent ratings (Horvath & Luborsky, 1993). For instance, a meta-analysis of twenty-four studies found that a twenty-six per cent difference in the rate of therapeutic success is attributable to the quality of the therapeutic alliance. In another benchmark study by Krupnick et al., results indicate the therapeutic alliance has as much impact on the outcome effects as active and placebo

pharmacotherapy. In addition, Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) examine the effect of cognitive therapy on depression and establish client emotional experiencing and therapeutic alliance are both strong informants of client improvement.

Like the therapeutic relationship, definitional notions that clarify the meaning of the alliance continue to evolve. However there is general consensus the alliance includes those aspects of the relationship that facilitate the collaborative work of therapist and client (Bordin, 1979). Different conceptualisations and measurement approaches emphasize different components such as the affective relationship between the parties and specific activities of client and therapist. Moreover some authors use the term alliance quite broadly to include various aspects of the therapy relationship whereas others use a more concise definition. Due to these theoretical developments, a plethora of research has produced a variety of scales to measure the effect of the alliance in a number of different ways. These include the Helping Alliance Questionnaire (Luborsky, 1976); the Vanderbilt Psychotherapy Process Scale (Gomez-Schwartz, 1978), the Working Alliance Inventory (Horvath & Symonds, 1991), and the California Alliance Scales (Gaston & Marmar, 1994). Although a detailed discussion of these instruments is pertinent to the empirical literature, this is considered to be beyond the scope of the thesis question. Having considered the empirical evidence with regard to the outcome effects of the therapeutic relationships, the next task of this review examines the effect of the therapeutic relationship in terms of the qualitative literature.

Qualitative Research on Relationship Factors

Although qualitative inquiry with regard to relational factors is limited, a number of studies establish the therapeutic relationship has a positive effect on client development and change. Although a full account of this research is beyond the scope of this inquiry, a snap-shot of these studies is presented. Indeed several exploratory studies acknowledge the characteristics of good therapeutic relationships impact on outcome effects. These include the effect of empathy (Bischoff & McBride, 1996), engagement in the therapy process, awareness of the subtleties of

therapeutic events, and being understood (Howe, 1996). Specifically, Howe describes the goals of this research as “the interest was not in whether the presenting problem had been ‘cured’ in some objective, measurable sense, but rather in whether or not people *felt* they had been helped” (p. 369).

Bachelor (1995) examines client perspectives on the effect of the therapeutic relationship by reviewing client accounts of their experience in various stages of their therapy. The phenomenological analysis identifies three features of the therapeutic relationship identified by clients as change informants. These include nurturing, insight-oriented, and collaborative stages of the therapeutic alliance. In an earlier, closely related study, Bachelor (1988) explores the impact of therapist empathy, identifying four kinds of client-perceived empathy. These include cognitive forms of empathy, affective empathy, therapist sharing, and therapist nurturing forms of empathy. Consequently, the study concludes empathy is not just a one-dimensional construct but a variable notion characterized by different applications in different contexts that has a profound impact on client/therapist relatedness.

Knox, Hess, Petersen, and Hill (1997) analyze client interviews with regard to therapist self-disclosure and establish that such revelations are helpful in advancing the therapeutic relationship providing they aim to normalize or reassure clients. Alternatively, therapeutic mistakes are used to study the effect of the therapeutic relationship on outcomes. Rhodes, Hill, Thompson, and Elliott (1994) found that client willingness to be open and honest about being misunderstood, in the context of a strong therapeutic relationship, coupled with therapist ability to tolerate client negative emotions leads to enhanced client outcomes. Impasses within the therapeutic relationship are also considered in terms of client outcomes. Hill, Nutt-Williams, Heaton, Thompson, and Rhodes, (1996) conducted post therapy interviews with therapists whose clients left therapy due to relational impasses. Accordingly, the study found that therapist/client relational impasses perceived by therapists have a negative effect on both parties as well as their relationship.

In summary, qualitative research into the therapeutic relationship reveals a similar narrative to quantitative research. The relationship represents a focus of intense inquiry for both traditions and yields similar conclusions. Qualitative investigation suggests client perceptions of the therapeutic relationship are of great importance to the process of therapy and should be actively monitored and incorporated into any chosen theoretical approach. In addition, compelling evidence links client perceptions, expectations and feedback, with strong therapeutic relationships and favorable outcomes (Maoine & Chenail, 1999).

Placebo Hope and Expectancy Factors

Research on psychotherapy outcome examines the importance of expectancy and placebo effects on client change. As indicated, Lambert (1986) assesses these factors contribute to fifteen per cent of client effects. Moreover more recent research by Wampold (2001) affirms this meta-analysis. Essentially, this research contends that factors such as hope and expectancy contribute to client change by their mere presence. Essentially when clients have an awareness they have been exposed to some sort of therapeutic intervention, this facilitates positive outcome effects. Clients know they have been exposed to some form of intervention and trust this process. Frank and Frank (1991) posit this form of expectancy implies that therapies are successful when client and therapist believe in the restorative power of the intervention's procedures or rituals. In essence, these curative effects emanate from the positive and hopeful expectations that accompany the implementation of any form of treatment.

Initial investigation of these factors occurred when Frank, Gliedman, Imber, Stone, and Nash (1959) ascertained that expectations clients bring to therapy have an important effect on outcomes. These inquirers established clients are more likely to improve as a consequence of therapy as their distress increases. In addition, Garfield's (1994) research suggests there is a positive relationship between client expectations and client improvement. Research on these placebo effects contends these elements have a significant impact on psychotherapeutic change. Indeed Lambert, Weber, and Sykes (1993) summarize studies comparing the effect size of

psychotherapy, placebo and no-treatment controls. The results indicate clients who are in receipt of a placebo treatment are better off than sixty six per cent of the no-treatment controls. On the other hand the average client who undergoes therapy is seventy nine per cent better off than the no-treatment controls. However placebo effects appear to be less significant in clients who suffer from more severe disorders and in studies where more experienced therapists are used (Barker, Funk, & Houston, 1988). The final category of common factors to be reviewed comprises technique and modality factors. Although, initially, these were coined non-specific factors, this category of change events is incorporated into Lambert's (1986) taxonomy as a factor responsible for fifteen per cent of client outcome effects.

Model/Technique Factors

Hubble et al. (1999) contend model and technique "factors may be regarded as beliefs and procedures unique to specific treatments" or "more broadly as therapeutic or healing rituals (p. 10)". This implies this class of factors provides a rationale and explanation for client difficulties as well as strategies for resolving problems. Typical examples include the miracle question in solution focused therapy, the use of the genogram in Bowen-oriented family therapy, hypnosis, systematic desensitization, biofeedback, and transference interpretations. As discussed previously, enthusiasm for researching the effects of specific schools or frameworks persists because of allegiance to school-based approaches by therapists. In addition, modality research is popular as the most suitable control group for past as well as future studies is often considered the best alternative treatment. Therefore specific interventions are frequently researched in the context of comparative outcome studies. However, models and techniques in and of themselves have been shown to have little influence on the outcome of treatment (Ogles et al. (1999). While exceptions do occur within the research literature, specific effects are thought to contribute minimally to outcome changes. Having established that empirical research determines that common factors, found in all therapies, are the key informants of

client change, this discussion explores the limitations of this stance espoused by informed commentary.

Criticism of Common Factors Line of Inquiry

There are a number of criticisms hailed at the common factor model aimed at its correlation with client change. Although many of these criticisms are interrelated, they are dealt with individually in the following arguments for the sake of clarity. Firstly, the strongest of these considerations turns on the fact that although common factors are viewed as the necessary ingredients of therapeutic change, it is asserted that, in themselves, common factors are insufficient to induce change. The general assumption that underpins this paradoxical stance implies that common factors, together with specific techniques aimed at specific disorders, jointly embody what makes therapy work. Thus, despite decades of empirical research challenging modality contribution, specific ingredients are still considered critical to the therapeutic process. This criticism reflects Asay and Lambert's (1999) contention, that notwithstanding the misguided brand wars, many theorists still depend on specific factors to supply "an extra boost" (p. 41) to ensure client change.

Secondly, another major critique contends that this focus on common factors conflicts with the competent application of specific treatments. For instance, Sexton, Ridley, and Kleiner (2004) argue the inclusion of independent common factors disconnected from the specific treatments, has a deleterious effect on the therapeutic encounter (Sommers-Flanagan & Sommers-Flanagan, 2004). Indeed, London (1964 cited in Lazarus, 1989, p. 33) asserts it is technique, rather than theories, that are actually applied in the therapeutic context.

Thirdly, critics contend the advocates of common factors are 'blind believers' imbued with the religiosity of common factors. This stance attacks the belief that all therapists have the capacity to facilitate effective therapy by merely creating warm, empathic relationships. Imel and Wampold (2008), critics of this simplistic approach, question whether clients somehow magically improve when therapists create a cozy

environment. Furthermore, these theorists also state common factor rhetoric creates a polemic between its advocates and oppositional interests that support the specificity claim of this debate. This manifests as a polarized division between the advocates of clinical trials, scientific knowledge, and those who eschew the findings of science in favour of a more humanistic view of change.

Fourthly, many theorists also claim a common factors approach is unsupported by theoretical constructs. To evidence this criticism they point to a dearth of integrated theories of change within the common factors literature. Specifically, they draw on the gradual accumulation of lists of common factors and the lack of differentiation between specific treatments. Accordingly, these views give rise to the perception that all effective psychotherapists need do is choose from a bag of common factors and forgo the arduous application of a specific theory (Lambert & Barley, 2002). In addition, many descriptions of common factors are broad as they often appear in list form, giving little attention to the mechanisms that effect change (Weinberger, 1995).

Fifthly, a number of theorists, including Orlinsky and Howard (1986), charge common factor models lack the scrutiny of empirical science. Specifically, Imel and Wampold (2008) claim this omission stems from the fact that common factor models are generally offered as alternatives to specific psychological treatments that fail to hold up to empirical scrutiny. As common factor models are developed with the primary purpose of accounting for the effects of conflicting theories that advocate diametrically opposed treatment rationales, it is not surprising that common factor theories are often avowedly atheoretical (p. 257).

Sixthly, a further rebuke attacks the common factors model for its failure to include constructs of experimental or social psychology as theoretical rationales. For example, positive therapist characteristics are often cited as important common factors, yet it is generally unclear why these common factors lead to client change. Little attempt is made to incorporate theories of change that inform this conclusion. Moreover, reviews of the impact of the therapeutic relationship on outcome effects

are generally incomplete as they fail to provide an in-depth social or developmental rationale for this outcome. Likewise positive client expectation is often cited as a common factor related to outcome effect yet there is little attempt to develop explanations as to how client expectation leads to change (Greenberg, Constantino, & Bruce, 2006).

Seventhly, the medical model and its scientific principles that privilege specificity oppose the common factor models because it does not view treatment theories as important guides to change mechanisms. Accordingly, this stance distinguishes psychotherapy from the medical model and harms its prestige. In essence, researchers posit that to reject the medical model is to reject science (Wampold, 2001).

Eighthly, frequent attacks on common factors claim the Dodo Bird Verdict is empirically incorrect. Craighead, Sheets, Bjornson, and Arnarson (2005) argue the sample sizes of meta-analyses that prove the Dodo Bird Verdict are too small to capture treatment differences. Alternatively theorists such as Weinberger and Rasco (2007) argue that if the Dodo Bird Verdict is correct, this does not necessarily lead to the notion that common factors are responsible for client change. Kazdin (2005) argues the legitimacy of the Dodo Bird verdict does not necessarily support the case for common factors, submitting most therapeutic modalities are likely to be effective for a number of reasons. Therefore therapeutic success cannot be explained by common factors alone.

Ninthly, researchers such as Chambless, (2002) and DeRubeis, Brotman and Gibbons (2005) point out treatments and therapies are blended together in any meta-analytical context. Consequently treatments that may be particularly appropriate for specific disorders are generally lost in the overall experience of a meta-analysis. Although this form of empirical criticism is beyond the scope of this thesis, it is interesting to note that Wampold (2001), an eminent researcher who reviews outcome effects from empirical, historical, and anthropological perspectives refutes this stance (Beutler, Moleiro, & Talebi, 2002).

Finally a number of theorists posit more systematic process research is necessary to assess the actual effect of common factors. To date these recommendations focus on the need for empirical research that examines different kinds of treatment across varied categories. Indeed, Weinberger and Rasco (2007) suggest future process research be conducted “to determine the exact loci, strengths and generalizability of common factors (p. 120)”. Weinberger and Rasco also recommend the use of experienced therapists whose insights are likely to support the examination of important facets of common factors. Furthermore, these researchers contend further qualitative and quantitative investigation would do well to examine the therapy of successful therapists naturalistically. In short, this course of action attempts to determine what effective practitioners do and how they make use of common factors. Indeed, Westen and Weinberger (2004) argue practitioners are a rich resource of material to draw on in this discovery phase of science. As they posit that therapists are successfully employed in studies examining diagnostic categories they contend practitioners be utilized as a valuable resource for outcome and process research.

Nevertheless, scholars assert that a call for process research does not mean the cessation of outcome research. Rather, they contend outcome studies are likely to be far more meaningful when supplemented by process research that addresses various common factors specifically. This integrated approach may help practitioners develop aspects of their praxis such as the therapeutic relationship. Furthermore, it encourages practitioners to contemplate the expectancies of clients and develop exposure techniques that fit into the type of therapy they provide. In addition, an integrated program of process and outcome research is likely to help therapists to actively encourage client mastery experiences. This could be achieved by motivating clients to view positive outcomes as changes that may be attributed to their own know-how.

In a constructive critique Stricker and Trierweiler, (1995) recommend all practitioners collect local data within the context of their practice to help bridge the gap that exists between empirical researchers and practitioners. Accordingly, this approach moves from privileging de-

contextualized evidence-based practice to a new paradigm of “practice based evidence” (McLeod, 2001, p. 23). Indeed, Margison, Barkham, Evans, McGrath, Mellor-Clark and Audin et al. (2000, p. 124) define this as “the gathering of good quality data from routine practice” whilst Aveline (2006) adds “these inferences are drawn from naturalistic unselected client populations....Routine monitoring of outcome is an essential component with performance feedback to the clinicians and the service as a whole” (p. 19).

As these criticisms of common factors highlight the need for more process research, this review turns its attention to a consideration of the process literature and its contribution to uncovering what makes therapy work. As this assessment has already considered the historical development of process research and strategies of quantitative and qualitative process investigation, this commentary focuses on the overt and covert processes that contribute to effective psychotherapy.

Events Paradigm in Process Literature

Earlier in this chapter this review presented a historical overview of process research and concluded this aspect of the therapeutic landscape is characterized by a multiplicity of complex and fragmented theoretical approaches and practical applications (Anchin, 2008). As a full examination of these multiple mediators exceeds the parameters of this thesis, this review selects the kinds of processes that are most relevant to the thesis question. Accordingly, this includes research based on client centred processes (Rogers, 1957), clinical change events (Greenberg, 1986), psychoanalytic process developments (Elliott, 1983), and process-outcome correlations (Orlinsky, Rønnestad, & Willutzki, 2004).

Client Centred Process Research

Rogers (1951) undertook a comprehensive study of client centred therapy to assess its empirical status. As an initiator of scientific research, this program implemented methods of inquiry in a systematic manner to test and develop theory in a rigorous and robust manner. The first phase examined process items such as Rogers’ (1951) notions of non-directiveness and self-acceptance that relate to therapist and client behaviours. The

second stage explored the relationship between therapeutic processes and client outcomes by developing new research techniques such as the Q-sort (Rogers & Dymond, 1954). Although numerous researchers pursued both research approaches (Barrett-Lennard, 1986), the final stage of the program brought a new level of investigation achieved by few researchers. Specifically, this examined the “core conditions” that exist between client and therapist that Rogers (1957) considered “necessary and sufficient” (p. 95) to induce client change (Kirschenbaum & Jourdan, 2005).

To advance this objective, Rogers (1959) mobilized a series of studies that measured therapist empathy, unconditional positive regard, and congruence. However these efforts encountered methodological difficulties causing numerous theorists to dispute Rogers’ findings. Furthermore, researchers found Rogers’ conceptualisations failed to clearly differentiate the notion of acceptance from the experience of congruence (Bohart & Greenberg, 1997). As these methodological problems remained unresolved, initially, the majority of psychotherapists considered Rogers’ core conditions confusing despite numerous research efforts to attest to their veracity. Nonetheless, as a number of critics like Watson (1984) claim these research efforts lacked rigour, conclusive judgments about Rogers’ postulations prove elusive (Greenberg & Geller, 2001). Nevertheless, Patterson (1984) and other commentators argue current trends in empirical research increasingly favour validation of Rogers’s core conditions model.

Notwithstanding this initial resistance, Rogers’ model has been absorbed by the gradual evolution of Bordin’s (1976) therapeutic alliance. In addition, each of Rogers’ core concepts, namely empathy (Barrett - Lennard, 1981), unconditional positive regard (Bohart & Greenberg, 1997) and congruence (Greenberg & Geller, 2001) are re-defined and accepted by more recent research. As much of this research assessed Rogers’ core conditions to be strongly correlated to therapeutic change, they are explored as overt change mechanisms later in this discussion. Essentially the difficulties of the client centred program are important because they illustrate the many deficits of process research. This program reveals the problems researchers encounter when they seek to validate important

therapeutic precepts through quantitative evaluation (McLeod, 2003). Rogers's process research indicates that even when researchers have the ability to construct theories these notions lack empirical verifiability (Barrett-Lennard, 1981). To some extent this deficit stems from the limitations of research based solely on the observation or description of empirical variables (Rennie, 2004a).

As a result of these difficulties, many researchers claim the study of the micro processes of significant events that occur within the therapeutic environment is more appropriate (Elliott, 1984) as a vehicle to examine what makes therapy work. Accordingly, this review turns its attention to a discussion of this form of research.

Significant Events Process Research

Elliott and Shapiro (1992), instigators of the significant events paradigm, consider portions of sessions lasting only a few moments are therapeutic when they bring clients an experience of meaningful change. As these researchers view micro moments as windows "where the 'action' is likely to be" (p. 164), they coin investigation into this phenomenon "events paradigm research" (McLeod, 2004. p. 154). Initially Elliott (1984) pre-empted this approach with the development of a research instrument described as Comprehensive Process Analysis (CPA). This discovery-oriented approach views clients and therapists as guides in the uncharted territory of therapeutic change (McLeod, 2003). Essentially, CPA aims at eliciting therapist and client explanations for significant moments of psychological change. This rationale rests on the assumption that when researchers supply therapy participants with the means to describe experiences surrounding specific therapeutic change events, this leads to the development of models with the power to induce these processes. Hence CPA asks clients and therapists questions about the quality the therapeutic alliance and the general coping style of clients. It also reviews key markers that characterize these events such as therapist and client responses and the impact of these responses on outcomes.

To realise this objective, researchers generally request clients and therapists view their therapy sessions that are recorded on videotape separately to identify the most helpful incidents. These accounts culminate in expanded narratives that reveal explicit and implicit meanings. In addition, independent observers review these videotapes to identify beneficial events of the session. Accordingly, when an expanded version of the original therapeutic session is constructed from these multiple viewpoints, researchers ask all participants to respond to quantitative and qualitative questions. These address the context, form, and impact of these specific therapeutic events. Finally, researchers construct client, therapist, and observer understandings through an iterative process of data analysis. This exploration highlights the similarities and differences of these accounts that Elliott and Shapiro (1992) describe as “consensus version of an event” (p. 173).

The events paradigm of process research is similar to the task analysis of Rice and Saperia (1984) and the significant incidents stance of Mahrer and Nadler (1986). All three approaches consider therapist client micro-processes are primary vehicles of therapeutic change. Although these researchers espouse contrasting ideas on the most suitable method to make sense of a therapeutic event, they all conclude micro-processes constitute primary vehicles of client change. Nevertheless, despite the contribution of these methods, the impact of the psychoanalytic tradition cannot be overlooked. Indeed some of the most powerful and clinically relevant process ideas have evolved out of the psychoanalytic tradition.

Psychoanalytic Process Research

Therapeutic processes traditionally identified by Freud (1912) include transference, counter transference, interpretation, free association, and resistance. However the study of these processes presents considerable methodological challenges. For instance, some therapists argue only individuals who are trained in analytic theory have the capacity to identify these processes. Thus research undertaken by untrained individuals has always been considered untenable. Furthermore, some therapists claim that constructs such as transference and counter transference are so subtle that

only seasoned therapists have the capacity to comment on them. Consequently, researchers generally use highly trained clinicians to make sophisticated judgments about these processes. For instance, Luborsky et al. (1986) developed the Core Conflictual Relationship Theme Method (CCRT) that examines transference reactions. Generally speaking, these themes relate to the wishes, needs, and impulses of clients and therapists with regard to a significant character within a narrative that emerges in a therapeutic session. In essence, this approach demonstrates that core relationship themes reveal strong support for Freudian transference. Nonetheless, a number of theorists emphasize the limitations of this method (Luborsky, 1990). Accordingly, over time these deficits opened the door to a new synthesis of research ideas known as process-outcome research (Hill, 1990).

Process-Outcome Research

Studies initially carried out by client centred therapists (Robinson, 1950; Rogers, (1951) find that process variables impact significantly on client outcomes. Indeed, McLeod (2003) asserts the ultimate goal of process research aims to make a contribution towards the increased effectiveness of psychotherapy. This stance is affirmed in an authoritative review of the process-outcome literature by Orlinsky et al. (1994). This research collates the results of more than two thousand process-outcome studies spanning a forty year period and confirms the quality of client participation in psychotherapy represents the most important determinant of therapeutic outcome (p. 361). In addition, it affirms the therapeutic bond as significant in mediating the process-outcome link. It also stresses that favourable client outcomes depend on the level of empathic, affirmative, collaborative and self-congruent therapist involvement. The study also viewed skilful application of therapist confrontation and interpretation as important contributors as well. Essentially, the findings of this influential review affirm Rogers' (1951) facilitative conditions are effective forms of therapy. Despite the multiplicity of methods that investigate process research this review contends they share two underlying common themes that point to the complexity of this kind of investigation. These relate to the unit of

analysis used to test therapeutic process and to the observer perspective adopted in this encounter. Each of these patterns is examined as the next task of this review.

Common Themes in Process Research

Firstly, studies of therapeutic process employ divergent units of analysis to examine whole treatments, single sessions, or significant segments of sessions that constitute the micro-processes implicit in these events. Thus as no one 'right' unit of analysis exists, researchers commonly adopt differing temporal lengths that produce variable results in their investigations. Not surprisingly, these decisions have important implications for the data inherent in these units. For instance, Mintz and Luborsky (1971) argue that it is almost impossible to ascertain the meaning of short therapy segments in the absence of knowing what occurred in the remainder of the session. Moreover, critics claim concentration on micro-sequences that comprise individual therapeutic events results in a loss of information about the overall context of the situation (Bachrach, 1981).

Secondly, a fundamental issue in process research addresses the choice of the observer perspective. Spence (1982) argues that participants within a therapeutic dyad possess such an intimate knowledge of the process that no one else can appreciate the complexities of the event. Furthermore, Spence maintains that any attempt to explain this experience to a third party alters the experience through the process of narrative 'smoothing' and polishing. In addition, Rogers and Dymond (1954) conclude therapists, clients, and observers have quite distinct perspectives of process and outcome. Although these outlooks frequently overlap, they also differ substantially at times. In an effort to redress this diversity many process researchers have used Interpersonal Process Research (IPR) methods to retrieve as much as possible from data that is smoothed away when the therapy hour finishes. Alternatively, other process researchers such as Elliott (1986) integrate client, counsellor, and observer perspectives in a single version of a therapeutic event. On the other hand Rennie (1990) constructs a rationale that focuses solely on the experience of clients.

Finally, it is important to note that, despite its fragmentation and division, process research has led to innovative and novel developments in psychotherapy. This is an impressive feat as process interactions are complex, multi-dimensional constructs that are difficult to unravel. This suggests that some form of integration that unifies these diverse developments may be necessary to bring about consistent and coherent mentalization to the field (Bateman & Fonagy, 2004). Although these ideas are explored later in this critique, the next task of this review takes a close look at the specific mechanisms of change, referred to as the overt and covert processes of psychotherapy.

Overt and Covert Processes in Psychotherapy

As previously discussed researchers employ diverse strategies to study therapeutic processes. Therefore it is difficult to provide a detailed assessment of these procedures in a coherent and concise framework. Consequently, this review adopts Kiesler's (1988) interpersonal transaction cycle as an approach suited to meeting this challenge. This method focuses on the exploration of overt interpersonal behaviours and covert intrapsychic experiences of individuals engaged in a therapeutic encounter. However, although this model has specific application to this discussion, it is important to note that the study of overt and covert interpersonal processes predates Kiesler's conceptualisation. Kagan (1975) introduces the idea that therapy participants experience diverse events at overt and covert levels. As Kagan's research establishes that greater awareness of covert events enhances the therapeutic enterprise, researchers gradually incorporate these concepts into researchable measures based on stimulated recall from tapes (Elliott & Feldstein, 1978; Hill & O'Grady, 1985). Over time the study of these overt and covert processes has intensified, legitimizing their relevance to the domain of psychotherapy (Elliott, 1985; Martin, Martin, & Slemon, 1989). Moreover as the interpersonal transaction cycle distinguishes overt and covert therapeutic processes in a comprehensive cohesive model, these ideas are highly regarded within the realm of empirical research (Hill, 1990; Rennie, 1994). Nevertheless, it is important to note a detailed understanding of Kiesler's (1988) model is beyond the scope of this thesis.

Essentially, this review draws on Kiesler's synthesis to develop an organizational device that structures the expansive process literature and facilitates clarity of understanding. Thus this critique argues an in-depth explication of Kiesler's interpersonal transaction cycle is unnecessary in view of this specific objective.

Moreover this classification of overt and covert processes is also adopted by other psychological domains such as behaviourism. In particular Powell, Symbaluk and Honey (2009) posit that overt behaviour has the potential for being directly observed by an individual other than by the person performing the behaviour. Although this study affirms behaviourists focus on the study of overt behaviour, they also point out that Skinner (1974) refers to covert behaviour as behaviour that may only be perceived by the one performing the behaviour. In other words, they claim that behaviour is subjectively perceived yet not publicly observable. Typically, covert behaviours include thoughts, feelings and sensory experiences that Skinner coins "private events" and "private behaviours" (Powell et al., p. 54).

Moreover, as the field of process research is littered with numerous attempts to investigate the mechanisms of client change (Elliott, 1983; Glass, 1976; Hill, 1990; Kazdin, 2007), this review adopts a strategy of expedience to investigate this domain. As many scholars view Roger's (1952) core conditions as transtheoretical concepts (Prochaska & DiClemente, 1982) that operate in a wide range of modalities (Gallagher & Hargie, 1992), this critique reviews them as overt processes that inform effective psychotherapy. In short, as empathy, unconditional positive regard and congruence are co-opted by a wide range of divergent modalities such as self-psychology (Kohut, 1985), emotion focused therapy (Greenberg & Johnson, 1988) and integrative therapy (Moursund & Erskine, 2004) this review critiques these processes in this broader context.

Additionally, in keeping with Kiesler's (1988) interpersonal transaction cycle, this review also examines meaningful therapeutic moments as covert processes that create positive outcomes. Although these constructs derive principally from person centred theory, Buber's (1937) dialogic and psychoanalytic ideas, they are recognized in a variety of

contexts such as existential and humanistic therapies (Rogers, 1952; Spinelli, 2007).

Finally, the notion of transference represents the last process to be reviewed by this discussion. Although this construct emerged in Freud's (1915) early psychoanalytic thinking, a plethora of scholars consider this covert phenomenon "will develop in any situation where one person is seeking help from another, trained person" (Greenacre, 1954, p.671). Even early theorists such as Lagache (1953) and Hoffer (1956) agree with Nunberg (1951) that "transference occurs also in other than psychoanalytic therapies" (p.2). Indeed Thompson (1945) begins her analysis of transference by stating that:

Transference was not created by psychoanalysis. As long as human beings have had relationships with one another, there have probably been irrational developments in these relationships. These irrational elements have been especially marked in the attitudes toward those upon whom a person is dependent. Therefore one sees it in all situations where one of the two people is in a position of authority in relation to the other (p. 273).

Thus this commentary views transference as a generalized covert process that shares much in common with the other mechanisms of client change examined by this review. All these dynamics represent powerful determinants of effective psychotherapy and client change. Accordingly, the next stage of this commentary constitutes a detailed examination of Roger's (1957) empathy, unconditional positive regard and congruence as necessary and sufficient overt processes in the therapeutic environment that lead to client change.

Overt Processes: Rogers' Core Conditions

Rogers' core conditions (1957) remain influential in international psychotherapy practice despite decades of equivocal research that queries their effectiveness. However reviewers argue that lack of clarity in Rogers' original definitions are major factors in the plethora of misunderstandings that occur around these processes. Nevertheless, despite these criticisms

researchers and theoreticians of diverse perspectives continue to employ these processes in the interpersonal environment of the therapeutic encounter.

Rogers's (1957) initial article that outlines the necessary and sufficient conditions that facilitate therapeutic change marks a seminal contribution to the domain of psychotherapy. This asserts that when therapists demonstrate "attitudes" (Irving & Dickson, 2006, p. 184) of unconditional positive regard, empathic understanding and congruence to clients with the capacity to perceive these attitudes, positive psychotherapeutic change is inevitable. In particular, Rogers (1957) claims these core conditions operate independently of any therapeutic approach. Specifically, he states "the techniques of the various therapies are relatively unimportant except to the extent that they serve as channels for fulfilling one of the conditions" (p. 102). Over time these attitudes were appropriated by diverse psychotherapists as essential pantheoretical processes. For instance Hill (2007, p. 260) an eminent process researcher, remarks:

Rogers has had a major influence on the field, even with people who are not humanistic in orientation..... Although I never knew him personally, my academic heritage goes directly back to him given that I was trained by people who were trained by people who trained with him. Indeed, my whole theory of therapy and my research career have been directly and substantially influenced by him. I have spent much of my career studying the process of therapy, specifically looking at the therapist's contribution to the process. And I have developed models of helping skills and dream work (Hill, 2004) that include an exploration stage that is founded largely on Rogerian ideas.

Moreover, many scholars argue these core conditions represent the fundamental interpersonal processes of many, varied therapy 'brands' such as emotion focused therapy (Greenberg & Johnson, 1988; Rice & Greenberg, 1984); acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999) and dialectical behaviour therapy (Linehan, 1993). Indeed, Josefovitz

and Myran (2005) developed an empathic model of cognitive behaviour therapy that implements these processes. Finally, in demonstrating the general application of these processes, a report published by the Task Force (2002) of Division 29 of the American Psychological Association concludes Rogerian empathy is essential to the praxis of psychotherapy. Furthermore, it declares Roger's other core conditions - unconditional positive regard and congruence are processes that are also likely to benefit clients. Consequently, in view of their significance, these processes are examined in the light of developments gleaned from a wide variety of therapeutic frameworks and research.

Empathy

There is no consensual definition of empathy within the psychotherapy literature, although Rogers's (1957) client centred therapy and Kohut's (1985) self psychology reflect on its meaning more than other therapeutic modalities (Kahn & Rachman, 2000). As a substantive body of informed commentary suggests that Kohut incorporates many of the processes developed by Rogers, this review focuses on Rogers's synthesis to explain the meaning of this construct (Clark, 2010). As Rogers (1949, 1951, 1957, 1959, 1975, 1980) refined his thoughts on the nature of empathy, it took him a series of publications over a number of years to define this notion unambiguously. In his initial formulation, Rogers (1949) declared the empathic function of therapists necessitates they "perceive the world as the client perceives it, to perceive the client himself, as he is seen by himself" (p. 86). Later, in his widely acclaimed treatise, *Client Centred Therapy*, Rogers (1951) restated these ideas adding the proviso that therapists are required "to communicate something of this understanding to the client" (p. 29). This indicates Rogers (1951) considered effective therapists assume an attitudinal stance conveying an understanding the actual experience of clients rather than taking a position of emotional identification:

In the next development Rogers (1957) published a comprehensive article that prescribed the necessary and sufficient conditions to enact effective therapy. Moreover this paper included a full explanation of

empathy, instructing therapists “to sense the client’s private world as if it were your own but without ever losing the ‘as if’ quality” (p. 99).

Accordingly, this enables therapists to “perceive the internal frame of reference of another with accuracy” (p. 210) by focusing on the other’s subjective perspectives. In attempting to explain the role of therapists when they adopt this ‘internal frame of reference’, Rogers stated therapists function as external observers who adopt a position of emotional detachment from clients. Essentially, Rogers instructed therapists to sustain a phenomenological viewpoint with regard to client perspectives throughout the therapeutic encounter that avoids advice or judgment. Rogers (1975) reaffirmed the importance of recognizing the subjective perspective of clients by stating:

To be with another in this way means, for the time being, you lay aside the views and values that you hold for yourself in order to enter another’s world without prejudice (p. 4).

However, over time Rogers (1959) began to recognize the vital importance for therapists to attune to the emotional experience of clients as well as understand the meaning of their perceptions. Thus Rogers included both affective and cognitive dimensions in his definition of empathy that envisaged a broad level of client functioning whilst avoiding emphasis of one quality over another. In addition, Rogers distinguished “the state of empathy” (Clark, 2007, p. 64) from the communication exchange that occurs between therapists and clients. According to Rogers, being in a state of empathy means therapists perceive the functioning of clients, accurately and sensitively, in the immediacy of the therapeutic relationship. Rogers also preferred the term ‘empathic understanding’ to describe the quality of therapist receptivity that appreciates client circumstances and communicates this to them (Schmid, 2001). Furthermore, Rogers (1957) stated therapists are obliged to “voice meanings in client experience of which the client is scarcely aware” (p. 99). Indeed, Bohart (2005) observed empathic therapists introduce variations in their client statements by using different words or drawing out implications from new or different angles. Thus, through the interpersonal experience of empathic understanding,

therapists verify or disprove inferences and hypotheses by consistently checking these with clients.

Finally Rogers (1975) presented a critical review of all the available research that examined the meaning of empathy and concluded this way of being represents “one of the most delicate and powerful ways we have of using ourselves” (p. 2). In this notable shift from his earlier position of a “the state of empathy” (Rogers, 1959, p. 210) Rogers referred to empathy as a “process” (1975, p. 4). With this semantic change Rogers offered a more precise depiction of empathy that implied sustained constancy of engagement (Watson, 2002). Citing extensive research evidence, Rogers concluded that “a high degree of empathy in a relationship is possibly *the* most important and certainly one of the most potent factors in bringing about change and learning” (p. 3).

In an effort to clarify Roger’s (1961) notion of empathy, Seeman (2002), a notable exponent of the humanistic ethos, developed a psychotherapeutic approach that fostered a “human-systems model of optimal functioning” (p.623). Essentially, this construct espoused that the human system and its component sub-systems are integrally linked in the expression of human behaviour. In shaping this synthesis Seeman drew on Bohm’s (1981, p.173) supposition that the parts of a system interact and are affected by each other in the process of changing the system as a whole. However, Seeman extended Bohm’s premise by asserting that optimal human functioning is informed by optimal interactions with multiple internalized sub-systems. He argued these interactions occurred on a continuum beginning at the base-level of molecular, bio-chemical processes that extended upwards to more molar sub-systems such as cognitive processes (p.624). In explicating this dynamic, Seeman claimed this movement was capped by interactions at the most molar sub-system, the person-environment dimension. Moreover, he viewed these interactions as mutually embedded, intimately linked processes that evidenced levels of “organismic connectedness and integration” (p.629). Although a full understanding of this model and its concepts is beyond the scope of this

thesis, his efforts are instructive as they form the foundation of a therapeutic approach based on empathy.

Fundamentally Seeman (2002) proposed that a fully-functioning person is characterised by organismic connectedness and integration. Conversely, he posited that human dysfunction indicates there are flaws in these ecological processes. Thus he devised a model of therapeutic praxis aimed at restoring these elements. Essentially, he suggested that when psychotherapists prioritize empathy, this facilitates their capacity to identify dysfunction at the various levels of their client's ecological system. Moreover, Seeman asserted that empathy also informs therapist ability to select modalities most suited to ameliorate these disturbances. Although this privileging of empathy reflects many of Rogers's concerns, Seeman's departs from the former's process-driven approach by conceding modality considerations impact on therapeutic efficaciousness (p.630). Indeed, according to Seeman, empathy constitutes a diagnostic tool that informs the selection of therapeutic methods most suited to alleviate blockages in the optimal functioning of the human system. Thus Seeman's treatise adds to Rogers's reflections on the central role of empathy and its influence on effective psychotherapy.

After Rogers's conceptualisation of empathy, scholars privileged it as the foundation of all psychotherapy helping skills training throughout the 1960s. However, in the 1970s psychotherapy researchers contested the universal application of empathy and by the late 1980s research on therapist empathy was greeted with skepticism and resistance. This trend ensured that psychotherapy researchers paid little attention to the concept for the next twenty years. Eventually this dearth of research led scholars such as Bohart, Elliott, Greenberg, & Watson (2002) to propose the time was ripe for a re-evaluation of empathy as a "key change process in psychotherapy" (p .89).

In attempting to kick-start this development, Bohart et al. (2002) supported Rogers' varied conceptualisations of empathy by arguing these notions represent a higher order category of knowledge. To evidence this they quoted Rogers' (1980) efforts to explain the meaning of empathy as

the “ability to see completely through the client’s eyes” (p. 85) and “being sensitive, moment by moment, to the changing felt meanings which flow in this other person (p. 142). Consequently, these scholars constructed empathy as notion of nested subcategories. Accordingly they posited that when therapists place themselves in the shoes of clients, they engage with these different sub-categories such as emotional empathy, cognitive empathy, or moment-to-moment empathy, or indeed the experience of all these sub-divisions, together.

Furthermore, Bohart et al. (2002) reviewed the literature and identified three distinct empathic processes that are not mutually exclusive. These included empathic rapport, empathic attunement, and person empathy. Empathic rapport embodies the compassionate attitude that therapists display towards clients. This process indicates that therapists make efforts to understand client experience so they can establish contexts that facilitate effective interventions. The process of empathic attunement consists of active, ongoing efforts by therapists to stay attuned to clients on a moment-to-moment basis. Empathic attunement centers on client communications and their unfolding process (Bohart & Greenberg, 1997; Orlinsky et al., 1994). This process does more than just communicate therapist understandings of client responses; it deepens and carries forward client exploration (Gendlin, 1968; Greenberg & Elliott, 1997). Finally, ‘person empathy’ (Elliott, Watson, Greenberg, Goldman, & Davis, 2001), also described as ‘experience near understanding’ (Bohart & Greenberg, 1997) or ‘background empathy’ (Lerner, 1972) consists of sustained efforts by therapists to understand client experience.

The process of empathy is also viewed as a professional trait or response skill (Egan, 1982) as well as an identification process that becomes the experience of clients (Mahrer, 1997). Scholars also consider empathy to be a hermeneutic interpretative process that assists clients in deconstructing their experience. In addition, Watson (2002) suggests empathy is a means of facilitating client affect regulation. Alternatively, O’Hara (1997) argues that empathy is the process of ‘getting inside the skin’ of the therapeutic relationship as well as the client. Although the

importance of empathy cannot be denied, the other Rogerian facilitative processes of unconditional positive regard and congruence are equally significant (Norcross, 2002; Patterson, 1984).

Unconditional Positive Regard

The concept of unconditional positive regard is an expansive way of describing Rogers' prescription that effective therapy relies upon complete therapist acceptance of clients. Indeed, Rogers defines this as "experiencing warm acceptance of each aspect of the client's experience" (Rogers, 1957, p. 98). This suggests Rogers' view envisages a caring therapist whose attitude is totally uncontaminated by judgments of client thoughts, feelings, or behaviours (Thorne, 2003). In seeking to elaborate the meaning of this construct, Hill (2007) describes it as analogous to warm acceptance, non-possessive warmth, prizing, affirmation, respect, support, and caring. Furthermore, she emphasizes that, as a therapeutic position, it conflicts with the view of many practitioners who assert the need to adopt an "expert, distant, neutral, dispassionate stance" (p. 262). Irving and Dickson (2006) submit this notion may be usefully conceptualized as a therapist attitude that comprises cognitive, affective and behavioural components. Its affective component constitutes caring for clients. Its cognitive component relates to the conceptual framework of therapists that enables them to make subtle distinctions between respect for client personhood as distinct from approval or disapproval of their actions. In defining the behavioural component of unconditional positive regard, Irving and Dickson claim the actual communication of caring is crucial.

However, despite the apparent ease of Rogers' (1957) conceptualisation, the notion of unconditional positive regard has been subjected to intense criticism over the years. Indeed, it is viewed as a problematic multi-dimensional concept, frequently misinterpreted in the literature. Wilkins (2000) argues it embodies Rogers' most controversial concept yet it is relatively neglected by informed commentary. Ford and Urban (1963) critique its subjectivity and level of abstraction whilst Kovel (1976) suggests it may even be harmful to clients as it privileges a lack of therapist objectivity. Brazier (1993) also notes difficulties suggesting it

underscores "our basic need is the need to love rather than the need to be loved" (p. 76). Moreover, Gelso and Carter (1985) contend it conflicts with therapist genuineness, another Rogerian concept. In keeping with this critical response Lietaer (1984) points out unconditional positive regard is a nefarious, multi-dimensional construct whose components are vague and unrelated to one another. This view is supported by many scholars such as Barrett-Lennard, (1978) Truax and Mitchell, (1971) and even Rogers himself (Rogers, 1957, 1962, 1967, 1977). Furthermore, factor-analytic studies reveal unconditional positive regard comprises a number of relatively independent processes that overlap. Although this fusion clouds its meaning, these processes do have significant client effects and are thus worthy of detailed explication.

As the term unconditional positive regard suggests, this notion includes a diverse notions of positive regard, non-directivity and unconditionality. Positive regard represents the therapist's affective attitude that values clients, believes in their potential, and cares for them in a non-possessive way. Indeed, Irving and Dickson (2006) claim this feature is explored in the literature more than other internal components of unconditional positive regard (Egan, 1998; Ivey & Authier, 1978; Truax & Carkhuff, 1967). Non-directivity refers to an attitude of respect that therapists display towards clients who are viewed as "unique and independent persons with the right to live according to [their] own viewpoint" (Lietaer, 1984, p. 42). As this quality constitutes respect for the right of clients to self-direction and self-determination, it represents cognitive aspects that relate to client underlying belief systems and philosophy of life. Finally, unconditionality refers to therapist capacity to demonstrate constancy of acceptance. Irving and Dickson (2006) claim this trait is potentially the most problematic and under-emphasized in the research literature (Watson, 1984). In a discussion of therapist respect and its changing role within the therapeutic encounter Carkhuff (1969) argues that as the therapeutic relationships develops, conditionality of therapist acceptance grows in importance. Specifically, Carkhuff states that emergence of conditional therapist respect with increased client

development has the potential to nurture and encourage client growth. Yet this conditionality is at odds with Rogers' (1957) stress on accepting clients for what they are rather than for what they might become. In view of this contradiction, Irving and Dickson argue Rogers' unconditionality be viewed in the context of his initial theory regarding the origin of psychological disturbance (1962). In short, Rogers believes the conditional love of significant others, particularly in childhood, is the basis of personal alienation. Thus Irving and Dickson contend therapist unconditionality acts as a counterbalancing force to earlier conditionality, enabling clients to get back in touch with themselves.

Congruence

As with empathy and unconditional positive regard, congruence is fraught with uncertainty. Although Rogers (1957) stresses a therapist is congruent when "freely and deeply himself, with his actual experience accurately represented by his own awareness of himself" (p. 97) many scholars interpret this statement differently. For instance, Lietaer (1993) draws attention to the multi-dimensional nature of congruence, claiming it consists of two distinct features: genuineness and transparency. Egan (1998) contends this construct embodies the capacity to be 'real' whilst Tudor and Worrall (1994) stress it is characterized by four elements: self-awareness, self-awareness in action, appropriateness and communication. In an attempt to clarify Rogers' ideas, Lietaer (1984) argues "congruence and acceptance are thought to be closely related to one another; they are parts of a more basic attitude of 'openness': openness towards myself (congruence) and openness towards the other (unconditional acceptance)" (p. 44). Alternatively, Pearson (1974) asserts congruence infers a paradoxical dimension of openness and defensiveness that manifests as a complex interaction of cognitive and affective factors. Accordingly this viewpoint considers a loss of congruence may occur at different levels of consciousness. For instance, this may happen at an unconscious level when therapists are unaware of denying or distorting their feelings, or, alternatively, when therapists consciously decide to hide their true feelings. Thus, as the working dynamics of congruence remain equivocal, it is argued

that further research is required to clarify its meaning and effect. As additional discussion of overt processes that impact on outcome effects are beyond the scope of this commentary, attention is turned to the covert interpersonal processes of psychotherapy that bring beneficial client change.

Covert Processes: Meaningful Moments and Transference Relationship

Covert processes denote “that which is not directly observable, often because it is disguised or concealed” (Corsini, (1999, p. 232). A number of researchers from diverse therapeutic frameworks stress the importance of these ‘concealed’ dynamics as crucial informants of effective psychotherapy (Greenberg, Rice, & Elliott, 1993; Mahrer & Nadler, 1986). In particular, scholars such as Stern (2004), Livingston (2009) and Rogers (1959) examine these covert elements as meaningful moments within the therapeutic environment that induce client change. In short, researchers distinguish these events as individual processes with different therapeutic effects. The most notable of these include ‘good moments’, ‘moments of meeting’, and ‘therapeutic moments’. Accordingly, each of these interpersonal dynamics is examined by this commentary with regard to its impact on client change.

Good Moments

Mahrer (1988) defines good moments in psychotherapy as ‘in-session events that indicates a significant measure of client movement, improvement, progress, process or change” (p. 81). Additionally, Mahrer, Nadler, Sterner, and White (1989) develop a list of good moments that occur within the interpersonal environment. These purport to cover all types of individual psychotherapy such as client selfhood, therapist/client relating, and expressions of insight as well as client statements of change. However in many of these cases clients are not necessarily aware of these events. Moreover, despite Mahrer’s generalized definition, good moments are principally investigated from the perspectives of a variety of specific theoretical frameworks. For instance Strupp, Chasson, and Ewing (1973) adopt a psychoanalytic stance to rate sessions as good moments in

psychotherapy. This reveals good moments occur when clients show cooperative attitudes and expressions of positive transference towards therapists. In a series of additional psychoanalytic studies, researchers acknowledge that emotional insight embodies a good moment of mutative change. Specifically, they postulate that when clients experience good moments they enter states of emotional arousal that capture new ways of seeing themselves (Elliott, 1984; Raskin, 1949; Strupp, 1980). Furthermore, Gassner, Sampson, Weiss, and Brumer, (1982) adopt a psychodynamic stance when they ascertain good moments in psychotherapy include material previously warded off by clients. Essentially, this confirms aspects of client cognition and affect, previously unavailable due to personal discomfort and defensiveness (Horowitz, Sampson, Siegelman, Wolfson, & Weiss, 1975).

Raskin's (1949) early emphasis on good moments led Walker, Rablen, & Rogers, (1960) to create a researchable scale that assessed positive client self-attitudes. Specifically, this measured client search for meaning by focusing on the identification of inner feelings as they experience change and resolution (Kiesler, 1971; Mathieu-Coughlan & Klein, 1984). Martin, Martin and Slemon (1987) also examined 'good moments' in the context of person centred therapy and established these instances centred on affective exploration and expression. Contrarily, these researchers also ascertained these events in the context of rational emotive therapy were associated with development of insight and new ways of behaving. Moreover, from an experiential viewpoint, researchers ascertained that open and direct expression of feelings and emotions typified good moments in psychotherapy (Haggard & Isaacs, 1966). This occurred when clients carried forward moments of deeper experiencing to contexts outside the therapy encounter or an engagement with profound personality processes that led to substantive shifts as well as experiential sampling of new ways of being (Mahrer, 1983, 1985). However, despite the frequent identification of good moments in therapy, more recently informed literature that explores these dynamics as covert therapeutic processes has adopted the notion of

'moments of meeting'. Accordingly, this notion is explored as the next task of this commentary.

Moments of Meeting

Moments of meeting are covert interpersonal processes of relational depth within the therapeutic relationship that contribute to effective psychotherapy (Cissna & Anderson, 2002). Although diverse therapeutic orientations refer to moments of meeting (Mearns & Cooper, 2005) they principally derive from psychoanalytic conceptualisations. Although varied analytic theories, such as intersubjective psychotherapy integrate moments of meeting into their philosophical orientation (Stolorow & Attwood, 1992), Stern's (2004) research is primarily responsible for the increasing popularisation of this interpersonal process. Specifically, Stern views moments of meeting as "the mutual interpenetration of minds" (p. 20) between therapist and client within their interpersonal encounter.

Stern (2004) elaborates on the meaning of this construct by describing it as a relational meeting that enables both client and therapist to share their individual mental landscapes. As part of this process, both parties engage in a deepening relational dynamic coined 'moving along'. Within this context, client and therapist sense their direction yet do not know when and how they will take the necessary steps towards an uncertain therapeutic goal. Stern refers to these steps as 'present moments' asserting they aim at finding answers to questions such as "what is happening here and now between us....what do I sense or know about how you experience me now....what do you know about how I experience you now" (p. 120)? In the midst of this uncertainty, Stern (1998) argues a spontaneous, affectively charged "hot" moment emerges he describes as a 'now moment'. This challenges existing relational patterns, creating tensions between the parties. However, if both client and therapist seize this de-stabilizing moment and meet it authentically, Stern asserts a transformational 'moment of meeting' arises. Essentially this new intersubjective state changes each of the parties in a "shared feeling voyage" composed of present moments, now moments and moments of meeting that together represent "a world in a grain of sand" (p. 371). These moments multiply as

relational interactions between the parties deepen, directing clients to embrace change in an evolving dynamic of effective psychotherapy. Additionally, Lyons-Ruth (1998) posits these are “special moments of authentic person-to-person connection between client and therapist that alter their relationship and the client’s sense of themselves” (p.321).

Therapeutic Moments

Theorists and researchers have long since acknowledged the existence of specific healing moments that occur within the interpersonal encounter between client and therapist (Merleau-Ponty, 1973). Perhaps the best known examples are Rogers’ (1959) ‘effective moments’ and Buber’s (1967) ‘dialogic moments’. Although these notions stem from different therapeutic orientations, they share a number of commonalities. In particular, as these processes are characterized by healing attributions they are operationalized by this thesis as therapeutic moments.

Both Buber’s (1967) dialogic moments and Rogers’ (1959) effective moments embody therapeutic events occurring between therapist and client that acknowledge mutuality. Cissna and Anderson (2002) argue that when mutuality occurs, therapists affect clients and are also affected by clients; therapists extend themselves towards clients but are also receptive to the impact of clients. This duality creates a reciprocal openness to mutual influence, emotional availability characterized by constantly changing patterns of affecting, and being affected by each other’s states. In short, client/therapist receptivity and client/therapist active initiative are simultaneously present. This creates a sense of expanding participation, engagement, and openness in both parties (Jordan, 1986). Cissna and Anderson, (2002) also allege Rogers’ (1959) effective moments resemble Buber’s (1967) dialogic moments as they share a series of common features that smack of mutuality. Furthermore, Cissna and Anderson point to a series of Rogerian concepts, similar to effective and dialogic moments. Rogers (1959) depicts these as ‘moments of movement’, ‘molecules of therapy’ and ‘existential moments’. These embody brief interludes that reveal a situation in which “two people happen to one another yet disappear in the moment of their appearance” (p. 78).

Finally, in considering the covert processes that make therapy work Gelso and Carter (1994) adopt Greenson's (1967) psychoanalytic formulation. This proposes psychotherapy consist of three components: working alliance, the transference configuration, and the real relationship. Significantly, these theorists apply Greenson's synthesis to all forms of psychotherapy, regardless of theoretical orientation. Although these features are the subject of a vast body of research and informed commentary, this discussion limits itself to a brief overview of these notions. Moreover, although the working alliance derives from Greenson's analytic understandings, there is general agreement that Bordin's (1979) explication leads the trend. This views the alliance as a pantheoretical notion that features within most modalities. As the working alliance is reviewed earlier in this chapter, the next task of this discussion focuses on the transference relationship and the real relationship

The Transference Relationship

In psychotherapy the transference configuration consists of both client transference and therapist countertransference. Although these constructs are the subject of a number of revisions over the years (Stolorow, Brandchaft, & Atwood, 1987), traditional conceptualizations view them as distortions, distinguishable from the working alliance and the real relationship. This stance adopts Greenson's (1967) initial conceptualisation that transference is the repetition of past conflicts with significant others in the here and now. Accordingly, client feelings, attitudes, and behaviours that belong to these earlier relationships are displaced onto therapists in current therapy relationships. However, despite their importance, definitions of transference and counter transference are complex, varied processes privileging client and therapist expectations that are difficult to identify. For example, Gelso and Carter (1985) postulate clients frequently experience feelings of disappointment towards their therapists long before they meet them even though the transference seems to manifest spontaneously. In addition, these theorists argue clients often possess inaccurate transference-based expectations of their own behaviour as well as the affect and behaviours of therapists. Moreover, Gelso and

Hayes (2001) posit clients tend to distort their perceptions of therapists to make them consistent with these expectations. Moreover clients also modify their own behaviours and feelings to conform to these expectations.

Although transference stems from psychoanalytic theory, Gelso and Carter (1985) argue transference configurations occur in all forms of therapy prior to or at the moment of initial contact. Moreover Jones (2004) claims transference configurations enlarge in specific modalities that focus on interpretation and 'working through' client/therapist encounters (Gill, 1982). Specifically, Jones posits this process requires therapists to observe and monitor client defensive patterns in the here-and-now of the therapy relationship. Indeed, therapists are expected to help clients focus on these patterns to fully experience their underlying feelings and emotions. In addition, Jones submits therapists are encouraged to assist clients to link past defensive behaviours, responses, and emotions to current relationships in the here-and-now of the therapeutic environment.

Apart from the curative potential of the transference relationship, Gelso (2002) posits transference configurations also affect the working alliance. Essentially Gelso asserts that positive transferences strengthen the alliance whilst negative transferences weaken it. Moreover Gelso, Hill, Jonathan Mohr, Rochlen, & Zack (1999) claim the working alliance influences the transference relationship through client awareness, expression of transference-based feelings and relational buffering against the effects of negative transference. These theorists also point out the working alliance also influences and is influenced by therapist countertransference. Thus therapist careful monitoring of countertransference reactions supports the independence of the working alliance. Many scholars also view therapist countertransference responses to client material as universally beneficial to the therapeutic endeavour (Gelso, Hill, & Kivlighan, 1991; Weiss & Sampson, 1986). Bacal and Newman (1990) contend that as therapists seek to understand their conflictual emotional reactions to clients, they appreciate them more deeply. Accordingly, these insights enable therapists to devise responses that are more helpful to clients.

Finally, although Gelso and Carter (1994) stress the importance of the transference configuration, they also emphasize that it may be beneficial, neutral, or destructive to clients and their therapy. Specifically, these researchers posit these processes affect client outcomes because therapeutic effectiveness depends upon therapist sensitivity when responding to transference and countertransference pressures. Finally, it is important to state that although the processes of transference and countertransference are subjected to scholarly theorizing, they have been neglected empirically (Robbins & Jolkovski, 1987; Gelso, Hayes, & Diemer, 1991).

The Real Relationship

The concept of the real relationship between client and therapist has existed since the earliest days of psychotherapy, although research focuses more on the working alliance and the transference configuration. Indeed Gelso (1985) posits that while the real relationship is historically aligned with humanist conceptions, it derives from analytic principles. Accordingly, in a recent treatise Gelso (2010) traces the development of the real relationship from its roots in early psychoanalytic thought, highlighting its current thrust in numerous modern therapeutic modalities. In particular, Gelso (2010) demonstrates the real relationship and its integral components are often misunderstood. Gelso highlights Greenson's (1967) conceptualisation of genuineness and Strupp's (1972) freedom from displacement as seminal events in the development of this construct.

Furthermore this explication refers to a synthesis by Gelso and Carter (1994) that posits the real relationship embodies twin components of genuineness and realistic perceptions. Essentially, the first element of genuineness is described as "the ability and willingness to be what one truly is, in the relationship" (p. 297). In a later formulation Gelso and Hayes (1998) extend this definition to a more expansive concept that includes "authenticity, openness, honesty, non-phonicity or Carl Rogers's (1957) concept, congruence" (p. 109). In terms of realistic perceptions, Gelso (2002) views this as the ability to perceive another in ways that are beneficial without projections or wished for dimensions. Essentially, this

submits genuineness refers to the ability to be authentic, open, and honest whilst realistic perceptions consist of ideas that are uncontaminated by transference distortions and other defenses.

Gelso and Carter (1994) also suggest that when therapist and client are involved in a real relationship, these parties cannot engage in a transference-based relationship. In short, genuineness and realistic perception states are incompatible with transference distortions. Graff and Luborsky (1977) conclude transference and the real relationship are mutually exclusive constructs that represent key components of the therapeutic relationship. Essentially, these are conceptualized as processes that exist side by side on non-overlapping, parallel dimensions. However contrary to this view, Stolorow et al. (1987) argue the transference configuration and the real relationship co-exist as they are related to one another in a number of crucial ways. Firstly, these theorists claim that as one of these components comes to the fore during therapeutic work, the other tends to recede. Thus when transference perceptions of therapists come to the forefront of sessions, their realistic perceptions of clients are moved to the background. Likewise, when realistic and genuine perceptions dominate the relationship, the transference configuration lessens. Secondly, Stolorow et al. argue that as the transference and countertransference distortion is understood and resolved, realistic perceptions take their place. For example, as clients come to understand their perceptions of therapists as critical, insatiable mothers are erroneous, they gain intellectual and emotional insight regarding the sources of that distortion. As this occurs, clients become more genuine in their relationships with therapists and view them in a more realistic light. Thus the transference relationship gradually recedes whilst the real relationship comes to the forefront of client and therapist connection. As the transference distortions are resolved, realistic perceptions take their place and genuineness increases. This implies the transference relationship changes throughout the course of therapy.

In completing this discussion on the real relationship, a critique that attacks the legitimacy of this notion from a postmodernist, social constructionist perspective is required. Although this notion has legitimacy

from a realist, modernist paradigmatic view, it is seriously challenged in the context of psychotherapeutic praxis that adopts postmodernist ideals. Accordingly, this discussion raises a number of questions that address this issue. Firstly, does the use of this term imply something within the therapeutic encounter is unreal? Secondly, what does the term 'real' mean anyway? Thirdly, who determines what is real or unreal? Is the client, the therapist or some other arbiter the entity that ascertains this state of affairs? Fourthly, even if someone is viewed as the authority on what is real, the question arises as to whether what is real can ever be fully known? Although Gelso (2002) attempts to respond to these concerns, it is argued by this commentary that as these notions are always subjective, constructivist and based on relativist considerations, they cannot be answered in general terms. Essentially, the question of what is real must always be determined by contextual concerns. Having concluded a review of the interpersonal processes that determine what makes a therapy, the last task of this commentary critiques these ideas.

Criticism of Process Research Line of Inquiry

As a full discussion of process research and its effect on client change is beyond the parameters of this review, this critique limits itself to an appraisal of the overt and covert processes raised in the previous section of this thesis. However, as numerous critics submit that process findings in regard to therapeutic change suffer from pervasive deficiencies and recurrent contradictions, reference to this broader criticism begins this assessment. Furthermore, this decision is informed by the desire to illuminate the politics of research and their role in the investigation of mechanisms of change.

General Criticisms

Firstly, it is important to realise that numerous critics contend process research is chaotic, disorganized, and inconsistent in its exploration of client change. Consequently, this confusion means researchers find it challenging to isolate effective therapeutic processes. Indeed some commentators argue this is as a direct result of ontological and

epistemological ideas that traditionally dominate process inquiry: namely rationalistic, positivistic, empiricism (McLeod, 2001). Accordingly, this paradigmatic approach is accused of restricting process inquiry to hypothesizing, inductive reasoning, and measurement-oriented findings. Therefore, critics assert this narrow approach limits development of exploratory, discovery-oriented process investigation. Nonetheless, despite its limitations, this "empiricalization" (Beutler, 1990, p. 263) cannot be solely blamed for the ambiguous and chaotic state of process research (Kiesler & Strupp, 2006). Indeed, numerous discourses posit the politics of research bear some responsibility (Ponterotto, 2005). For instance, in a startling admission Beutler (p. 263) acknowledges:

Years ago, those of us who heeded the persuasiveness of the outcome camp were taught to distrust those in the process camp. To us, these unfortunate souls were entrapped by their fuzzy concepts, their adherence to unsupportable theories, their largely non-empirical methods, and the ravages of extreme biases. We saw them as lost in the confluences of loosely defined, if not irrelevant, theories that we supposed supplied only fictitious explanations of how psychotherapy worked.

Moreover, this political persuasion is enhanced by fiscal concerns as eminent theorists such as Strupp (1973) allege funding for process research brings meagre rewards. Thus scholars and researchers are far more attracted to outcome inquiry that is well-funded by vested interests such as academic institutions and corporate interests.

Secondly, as a number of leading commentators charge that process inquiry is inherently unsystematic, this legacy of confusion and chaos continues in the present day. Specifically, Strupp (1973) argues process research is innately non-scientific as it was initially conducted by practitioners in the field rather than academic researchers. Moreover, Strupp asserts early researchers abandoned their inquiries after completing a single study without sharing methods or findings. Consequently, this neglect created a plethora of isolated and inaccessible knowledge that was overlooked in the evolution of process mechanisms. Moreover, Strupp

suggests researchers lack technical skills to undertake process inquiry. Therefore, lack of rigour in construct development manifests as ongoing, continuing deficits. This position contrasts with the precepts of outcome research that favour randomized controlled trials as more cohesive and structured forms of inquiry.

Kiesler (1973), a leading scholar in psychotherapeutic praxis, adds to Strupp's (1973) complaints. Specifically, he asserts that even though process developments that examine mechanisms of change are prolific, they are conflictual and divisive. Kiesler claims these failures stem from researchers being generally unaware of prior research gleaned in the early development of process methods. In particular, Kiesler views process research as a 'bastard child' (2006, p. xvii) of interdisciplinary activity that is increasingly complex as it is populated by diverse professionals from multiple disciplines. In an effort to ameliorate these problems, Kiesler catalogues the major process measures and links them across studies through the use of comparisons. Similarly, Greenberg and Pinsof (1986) and Russell (1987) follow suit, publishing extensive literary volumes of the major process measures. However, these efforts do little to clarify the major themes of process research as these emerge gradually over time, in a piecemeal fashion.

Conversely, a new generation of process researchers take issue with Strupp (1973) and Kiesler (1973) countering these criticisms. Specifically Hill, Nutt, and Jackson (1994) argue forcefully that significant, consistent process research emerges from a core of dedicated practitioner/researchers. This results in new developments such as the discovery-oriented and qualitative process methodologies (Elliott, 1984; Hill, 1990; Mahrer, 1988). Indeed, Hill et al. stress these advances enable researchers to break through some of the methodological deadlocks of the past. Furthermore, these scholars challenge Strupp's (1973) accusation that single studies typify process research. Instead, they identify a core of researchers who consistently advance process research. They point to Elliott, Greenberg, and Hill, as regular developers of frequently used research measures and the authors of classic process studies. Moreover,

other critics acknowledge these contributions as reliable indexes of research productivity (Shoham-Salomon, 1990). Although this more optimistic view is encouraging, developments in the process domain are said to consistently bewilder contemporary clinicians and researchers who try to come to grips with the contradictions in this elusive domain.

Numerous critics also advance a third criticism: that the inadequacies of process research are highlighted by the outcome camp endorsed by academic scholars and scientists. Not surprisingly, clinicians and practitioners who work in naturalistic environments are less accepting of outcome research yet more open to process research. Commentators suggest these diverse perspectives emanate from the early days of psychotherapy research when process inquiry pursued the methods of practitioners who judged progress on the basis of interpersonal behaviour. Unlike academically-oriented outcome researchers, these individuals do not have the luxury of waiting until the conclusion of treatment to evaluate benefits. Moreover empirically tested instruments that assess changes in clinical status are not always available in 'real-world' contexts. Therefore practitioners are forced to rely on clinical wisdom, tacit knowledge, and theoretical assumptions to guide and evaluate treatment effects. Yet, contrarily, these same guidelines are objects of suspicion to the scientific outcome researchers who see the world through academic ideals. Accordingly, it is suggested that empirical researchers earned the reputation of being disinterested in issues and methods likely to benefit clinicians. Thus process research assumes a secondary status when compared with the more prestigious domain of outcome research. Indeed, Beutler (1990) postulates these attitudes may well explain why empirical research has found limited acceptance in clinical practice.

A fourth criticism of process research infers that its ongoing segregation from the broader realm of outcome investigation results in its gradual demise. Indeed, Beutler (1990) concedes that:

We harkened to the creed, 'process without outcome is irrelevant,' and we saw in our misguided colleagues a certain lack of the virtue

that could only come from the type of empiricism that their procedures lacked and ours had (p. 262).

Leading researchers such as Kiesler (1973) attempt to dismantle this segregation but these efforts have been rebuffed by influential outcome authorities such as Garfield, (1990). Moreover Orlinsky and Howard (1986) integrate both these domains by classifying outcomes and processes into a comprehensive conceptual framework. However although this is expanded by a number of publications (Orlinsky et al., 1994; Orlinsky et al., 2004) separate lines of outcome and process inquiry remain.

In completing these general criticisms of process research that posit inquirers fail to practice scientific inquiry, it is interesting to note that the earliest examples of process research adopt empirical methods. Specifically, the legitimacy of psychotherapy is enhanced by the development of processes that measure Rogers' (1951) necessary and sufficient conditions (Truax & Carkhuff, 1967). In the same tradition, measures of the key dynamics of psychotherapeutic 'experiencing' (Klein, Mathieu-Coughlan, & Kiesler, 1986) pave the way for demystifying psychotherapeutic interpersonal processes, encouraging academics to investigate these processes empirically. In more recent times a variety of theoretical movements such as interpersonal, experiential, systemic, and psychoanalytic therapies operationalize constructs that inform their theories. Yet disagreements between those who advocate objective observations and those who advocate theory-driven data remain. Indeed, the splitting and division that characterizes outcome research also enters the territory of process research (Timulak, 2008). Having discussed some of the more general criticisms advanced against process research, this discussion turns its attention to specific criticisms that focus on the study of mechanisms of therapeutic change.

Specific Criticisms

To account for the discrepancies in the overt and covert process research presented by this critique, Lambert and Hill (1994) argue this form of investigation is still in its infancy as the field is still developing.

Nevertheless, most commentators do not deny that profound methodological deficiencies characterize research in both these realms (Llewelyn & Hardy, 2001). The first of these specific deficits refers to the diversity in the types of assessment that underpin most comparison studies. Variable parameters make comparison of overt and covert processes challenging and uncertain. Moreover, variant bases for selecting units and categories for these analyses create further confusion. Additionally, the development of new systems means that pre-existing studies are not replicated (Strupp, 1973). Thus critics charge these efforts are significantly unscientific. Additionally, the varied theoretical assumptions that underpin these studies make the identification of thematic patterns difficult. Furthermore, these studies are criticized for their use of small, unrepresentative samples that incorporate different definitions for the same construct. Indeed even the meaning of process itself lacks clarity and consensus. Furthermore, large numbers of comparative studies that evaluate process dynamics based on different theoretical approaches add to these difficulties. Finally, limited attention to the interpersonal context within the naturalistic world of psychotherapy is an ongoing complaint of process research.

A second criticism rails specifically against overt process research contends that Rogers' (1957) core conditions are ambiguous and equivocal even though they are absorbed into the praxis of psychotherapy and form the basis for skills development. For instance, in regard to Rogers's notion of empathic understanding, Book (1988) postulates that semantic and conceptual difficulties invariably occur. Regrettably, these result in confusion and uncertainty. Specifically, Book asserts that, from a semantic perspective, empathy is often confused with notions of sympathy or approval. In addition, conceptual discrepancies manifest when theorists fail to distinguish the intraphysic process of empathy from the interpersonal response of "being empathic" (p. 422). Indeed, even though Bennett (1995) describes empathy as a complex intrapsychic and interpersonal process, debates concerning the meaning of these constructs still continue in the literature. Likewise, although Barrett-Lennard (1981) points out Rogers

(1957) makes clear distinctions between 'feeling into' and 'feeling-with', these efforts make little difference to conceptual understandings. Moreover, in view of these difficulties Barrett-Lennard presents a model that incorporates both these meanings that conceptualize empathy as a complex and multi-level phenomenon. In reflecting on its complexity, Barrett-Lennard describes empathy as a "total attentional/experiential/communication sequence" (p. 93). These criticisms illustrate that even a basic process like empathy continues to be the subject of controversy and distortion that remains unresolved by research. Likewise, unconditional positive regard and congruence are viewed as problematic multi-dimensional concepts frequently misinterpreted in the literature (Lietaer, 1984; Wilkins, 2000). Their contradictory meanings and variable interpretations bring claims of incoherence and confusion that further muddy the map of process research

Thirdly, a further criticism of overt processes advanced by a number of authorities asserts that inconsistencies in Rogers' core conditions inhibit their influence and general respect for this type of research. For instance, Feller and Cottone (2003) investigated the notion of empathy and determined it has some application to all therapies. Nevertheless the study demonstrates that definitional and evaluation difficulties sustained in the investigation of empathy limit its professional worth amongst practitioners and researchers. Even though this study views empathy as a *necessary* ingredient that induces change regardless of modality, the study does not find that empathy is *sufficient* in itself to bring about change. Furthermore, the study finds that both unconditional positive regard and congruence are neither *necessary* nor *sufficient* to bring about therapeutic change. In general, these constructs are found to be generally less important in terms of clinical effects than empathy (Bohart & Greenberg, 1997). Although these studies are supported by similar research, nonetheless, Feller and Cottone determine that, in the twenty-first century, empathy continues to be as significant to psychotherapy as it was in the 1950s when Rogers (1957) first articulated its importance.

In contrast to the criticism of overt processes, the study of covert dynamics embedded in specific temporal moments receives increasing acceptance by a wide range of therapeutic interests. As the limitations of this critique restrict detailed discussion of these temporal units, it is important to point out that multiple kinds of meaningful moments are influential. For instance, although this literature review explores good moments, moments of meeting, and therapeutic moments as the most common micro moments in the literature, a vast array of temporal notions are omitted. These include creative moments (Stiver, Rosen, Surrey & Miller, 2008) vulnerable moments (Livingston, 2001), disengaged moments (Frankel & Levitt, 2008) and the like.

Although these meaningful moments explore differing dimensions of intrapsychic and interpersonal experience within the therapeutic encounter, they share a number of common features that contribute to a clearer understanding of what makes therapy work. Specifically, Cissna and Anderson (1998) point out that both Buber (1967) and Rogers (1959) agree that full mutuality manifests through fleeting temporal dimensions of psychotherapy. In a rare conversation in 1957 both theorists assert Rogers' effective moments and Buber's dialogic reveal specific transient, micro moments convey transparency, empathy, acceptance, and mutuality. Moreover, although Rogers and Buber consider these are beyond the awareness of event participants, these covert dynamics affect change in the intrapsychic of world of each individual and their interpersonal environment.

Although psychotherapeutic inquiry neglected these micro-moments for some time, Stern's (2004) recent conceptualization of moments of meeting in psychoanalytic psychotherapy popularizes these constructs (Gotthold & Sorter, 2006). In particular, Stern's articulation provides a more detailed explanation of these change processes and their temporal dynamics. Even though Stern examines these processes within a psychodynamic context, they are accepted by diverse therapists and modalities. Moreover, this kind of research privileges broader notions of empirical research that incorporates qualitative thinking and inquiry at

more localized levels. For instance, the Boston Change Process Study Group a cohort of practicing analysts, developmentalists and analytic theorists, committed themselves to the study of change processes in therapeutic interactions gleaned from developmental studies and dynamic systems theory. Consequently they have published a variety of books and journal articles that reflect these concerns.

Nevertheless, despite these encouraging developments researchers attack these ideas in a final criticism outlined by this critique. Specifically, this charges “the recent surge of interest in the mechanisms and processes of change has yielded lamentable few interpretable results” (Doss, 2004, p. 368). Indeed, a number of theorists submit the field knows relatively little about the mechanisms of therapeutic change (Kazdin, 1999; Kopta, Lueger, Saunders, & Howard, 1999). Although Paul (1967) asks “what treatment by whom is most effective for this individual with that specific problem, under which set of circumstances” (p. 111) this question is criticized. Detractors posit Paul misses the notion of ‘how’. As Kazdin (1999) points out a much more productive agenda focuses mechanisms, processes, and causes as the basis for therapeutic change (p. 534).

Conclusion to the Literature Review

This review of outcome and process research makes it clear that the field of psychotherapeutic inquiry is fraught with complexity and challenge. Indeed the prophetic words of Goldman (1977, p. 363) espoused more than thirty years ago, remain applicable:

What has research told us? Research has told us that most theories seem to have validity, but the variation in findings among different studies that test any one theory usually leaves us with no conclusive answers. Research tells us that some counsellors make some contribution to clients, but rarely does the study tell us what the crucial factors are that lead to success in one case and failure in another.

Although an array of authorities support these criticisms (Beutler, Williams, Wakefield & Entwistle, 1995; Stricker, 1994), Blocher (2000, p.

275) contends “they have had little avail” (p. 273). For instance, whilst studies by Orlinsky and Howard (1986) glean new insights, these are restricted in scope. Even though these researchers ask the basic question ‘what is effectively therapeutic in psychotherapy’, their findings are vague and general. Essentially, the understandings that follow, articulated by Orlinsky and Howard, indicate their view of what is effective therapy:

The patient’s and therapist’s therapeutic bond - that is their reciprocal role investment, empathic resonance and mutual affirmation - is effectively therapeutic; Certain therapeutic interventions, when done skillfully with suitable patients are effectively therapeutic; Patients and therapists focusing their interventions on the patient’s feelings are effectively therapeutic; Preparing the patient adequately for participation in therapy and collaboratively sharing of responsibility for problem solving are effectively therapeutic; Within certain limits, more rather than less therapy is effectively therapeutic (1986, p.371).

Accordingly, Blocher (2000) asserts these perceptions do little to illuminate the active ingredients of psychotherapeutic healing and suggests this set of conclusions is likely to be known intuitively by graduate students who successfully complete one semester of counselling practicum. Furthermore, he posits that follow-up research by Orlinsky et al. (1994) incorporating further more than one thousand studies adds little to this position. Nevertheless Blocher makes the point that psychotherapy research teaches us a number of important points that should be kept in mind. Firstly, that the relationship is very important and that some things work better with some clients than others. Secondly, Blocher encourages therapists to stay with client feelings and create a structure that imbues clients with a sense of the psychotherapeutic process and their responsibilities in this endeavour (p. 274).

On the other hand, there are some encouraging psychotherapeutic developments that challenge the dominance of rationalist positivism. Specifically, these centre on overcoming the empirical assumptions that underpin the aggregation of research data across individual clients and

therapists. This approach confronts the erroneous view that process variables and outcomes are similar across client/therapist pairings and problems. Indeed this stance takes issue with Kiesler's (1966) uniformity myth. Specifically, researchers are consistently engaged in sustained efforts to challenge this falsity by implementing exploratory, discovery-oriented inquiry that seeks to narrow the research/practice gap. Indeed Elliott (1983) comments on the need to initiate research efforts that meet the requirements of practitioners. In addition, Hill (1990) recommends the implementation of exploratory research to examine areas such as therapist techniques, client behaviour, process models, covert processes, and interactions between clients and therapists. Within this context, Hill defines exploratory research as an atheoretical form of study that describes therapy sessions by developing ways of analyzing interactions and the experiences of participants. In an effort to broaden this notion, Mahrer (1988) points out difficulties in restricting research to traditional hypothesis-testing and omission of context. Undeniably he argues psychotherapy evaluation simply does not generate refutable propositions crucial to the integrity of a proposed theory. In a scathing critique Blocher (2000) suggests the rise and fall of psychotherapeutic theories is "tied to the spirit of the times than to the number of times that its crucial tenets have been supported by research findings" (p. 278). Regrettably, this conclusion has some basis in fact that is evidenced by a review of the leading psychotherapy journals. This reveals the presence of a small number of exploratory studies when compared with the usual diet of statistically sophisticated studies. As Polkinghorne (1984) contends:

The practical work of counselling psychologists seems to bring them into relationships with people as integrated, whole beings who are able to reflect on and struggle over decisions, who sometimes make courageous choices...and who develop....imaginative responses to the stresses in their environment. Yet the research designs that are acceptable emphasize the passive and overt aspects of people - the empirically observable aspects. The designs seem incapable of explaining the everyday social behaviour of

human beings that is actually experienced by counselling psychologists (p. 422).

Chapter One Schematic Outline

Literature Review

Empirical Literature on Effective Informants

Two strands of empirical research: outcome & process: substantive but extensively challenged

1) Outcome Inquiry

- Preferred 'gold standard' of double-blind randomized experimental trials **BUT** omits contextualist real-world practice; ignores multiple problems of research populations & interpersonal client/therapist contact
- Focus on specific versus common factors debate criticized:
 - a) Specific factors = therapies thought to be active ingredients that make therapy effective
 - b) Common factors = client, therapist, relationship & extratherapeutic influences found in all therapeutic contexts **BUT**
- Critics argue specific factors alone limit investigation to 'battle of the brands'
- Common factors per se insufficient to induce change as specific/common factors act together
- Medical model attacks common factor research for lack of empirical scrutiny
- Constructivists challenge to common factor research for omission of theories of change

2) Process Inquiry

- Second strand investigates client/therapist behaviours: include significant therapeutic events, psychoanalytic processes & process/ outcome combined **BUT** Critics claim field fragmented thus overt and covert perspective identified by thesis helpful in addressing criticism
 - a) Overt process research = Rogers' core conditions of empathy, unconditional positive regard & congruence significant
 - b) Covert process research = 'meaningful moments' good moments, moments of meeting, therapeutic moments, transference relationship and real relationship **BUT**

General criticisms:

- Inconsistent, ambiguous and contradictory 'bastard child' research
- Positivistic hypothesizing, inductive reasoning, & measurement limitations

CHAPTER TWO

FOUR INTERRELATED LEVELS OF DESIGN

Whatever affects one directly, affects all indirectly. We are made to live together because of the interrelated structure of reality

(Martin Luther King, Jr. 1964)

Although four levels of design form the methodological structure of this thesis, Aristotle's (1976) notion of *phronesis* and Schön's (1983) reflection-in and on-action are paramount. These subjective perspectives assume a qualitative ethos shared by both participant and researcher evident in the content and process of the study. Participants adopt reflection-on-action strategies as they explore understandings regarding the features and informants of expert and effective psychotherapeutic praxis. This approach is paralleled by the researcher who engages in reflection-in-action to clarify and construct the meaning of participant understandings. Thus this duality in knowledge generation incorporates shared ontological, epistemological, methodological, and procedural considerations. Specifically relativist ontology is adopted whilst epistemological concerns address implicit understandings of participants. Apart from Schön's notion of professional learning, Dewey's (1933) reflective thought, and Peirce's (1955) abductive reasoning are relevant at the second level. At the next level phenomenological, hermeneutic and social constructionist considerations arise. In the context of this methodology, the researcher assumes the role of a bricoleur implementing substantive theorizing and critical reflexivity. This leads to a fourth level that embodies two discrete procedural phases. In the first phase, the attributes of expert praxis emerge from the understandings of West Australian psychotherapy trainers based on research material from one semi-structured interview. Each participant is also asked to identify three local psychotherapists they view as expert practitioners through a 'blind' nomination process. A new purposive sample emerges that forms the research population of the second phase of the study. Thus, in a series of unstructured conversations these individuals are asked to reflect on what makes therapy work. This process leads to the identification of overarching themes that conform to the usual standards of trustworthiness.

As this research is exploratory, Crotty's (1998) recommendations on researcher transparency are instructive. Firstly, he encourages researchers to reflect on assumptions that underpin any thesis question, identifying the most relevant methodologies likely to embody a response. Crotty contends researchers are obliged to name their view of reality and its effect on subsequent knowledge claims that emerge from a study. Moreover he adds they are prompted to select appropriate methodologies informed by these ontological and epistemological precepts. Finally, Crotty recommends methods and strategies conform to these ideas. Hence, this conceptualisation shapes the four interrelated levels of design that characterize this investigation. As this underpins the trustworthiness of its findings, details of this blueprint are revealed in this chapter.

Ontological Concerns

Psychotherapy is traditionally dominated by rationalist, modernist assumptions that affirm an objectivist reality. This realism supports belief in a 'true' world that is apprehendable, identifiable and measurable (Ponterotto, 2005). This framework of scientific inquiry is said to provide assurance knowledge generated by experimentation in a so-called accurate portrait of an external, objective reality. This realist position contends reality consists of natural categories differentiated by essential properties. Moreover, this approach posits formal reason governs rules and universal laws that determine reality. Thus when human beings reason rationally and logically, this is thought to overcome their subjective realities (Morrow, 2005). Accordingly, much of the research reviewed in this critique examines the informants of effective therapy is informed by realist ontology. However, as Polkinghorne (1999) declares, this position ignores contextual realities, social interactions, interpretative practices, and the subjectivities of parties. Thus, in a break with this dominant discourse, this study adopts a relativist worldview as its first level of design.

Relativist Stance

As Guba and Lincoln (1994) argue, relativist ontology denies the existence of an objective reality. Concepts such as rationality, truth, and

reality are always “relative to a specific conceptual scheme, theoretical framework, paradigm, society, or culture” (Bernstein, 1983, p. 8).

Accordingly, unlike many of the concepts explored in the previous literature review, this stance assumes reality is subjective and influenced by context. Consequently, this takes account of experiences, perceptions, social environment, and participant/researcher interactions (Neimeyer, 1995). Thus as this research implements these tenets, the first level of design assumes realities that are multiple, apprehendable, and equally valid (Schwandt, 1994).

With this mind, the study takes the form of two phases. These glean the subjective understandings of West Australian psychotherapists interpreted by the researcher. The first phase examines the perceptions of West Australian psychotherapy trainers and educators regarding the attributes of expert psychotherapeutic practice. The second phase examines the perceptions of peer nominated West Australian expert practitioners regarding the determinants of effective psychotherapy. Hence, both phases assume a plurality of realities informed by professional and personal influences acting on participant and researcher. Consequently, as ontological concerns reflect views of reality within a specific context, epistemological considerations informed by this stance mirror also this perspective. Accordingly, the next task of this review describes knowledge claims that underpin this study as its second level of design.

Epistemological Concerns

Despite more than four decades of investigation, empirical research based on the “logos of techne” (Polkinghorne, 2004, p. 11) fails to establish what makes therapy work. Consequently, this study looks to other forms of inquiry that address this question. Specifically, it draws on the philosophical ethos of constructivism that departs from the privileging of technification and skill development. Instead, this research draws on Aristotle’s (1976) notion of phronesis, described by Polkinghorne (1999) as judgment-based practitioner wisdom in the context of psychotherapy. Based on Crotty’s (1998) understandings this approach is considered most appropriate to identify the qualities of expert psychotherapists and the

determinants of effective psychotherapy praxis. As this philosophical notion of phronesis is allied with constructivist epistemology, the next stage of this discussion examines the constructivist stance within research, its historical development, and relevance to the thesis question.

Constructivist Stance

Essentially, constructivists hold reality is constructed in the mind of the individual (Hansen, 2004). This approach contends research outcomes are revealed through the process of deep reflection (Schwandt, 1999; Sciarra, 1999). As this is stimulated by researcher/participant dialogue, a distinguishing feature of constructivism focuses on interactions between researchers and the object of their inquiry. Essentially, researcher and participants co-construct findings from their interpreted interactions. Hence the goals of constructivism are both idiographic and emic (Ponterotto, 2005).

The seeds of constructivism may be traced back to Kant (1781) who insists that “human perception derives not only from evidence of the senses but also from the mental apparatus that serves to organize the incoming sense impressions” (Hamilton, 1994, p. 63). This ethos highlights a central tenet of constructivist thinking: an objective reality cannot be separated from the subjectivity of participants who experience, process and language this phenomenon (Sciarra, 1999). Thus multiple realities are consistently constructed and reconstructed by participants and researchers. This distinction highlights the basic difference between objectivist and constructivist positions (Ponterotto, 2002).

In addition, Dilthey (1894/1977) rejects reductionistic, objectivist ideas, distinguishing *Naturwissenschaft* (natural science) from *Geisteswissenschaft* (human science). *Naturwissenschaft* aims at scientific explanation (*Erklären*) whilst *Geisteswissenschaft* centers on understanding (*Verstehen*) social phenomena (Schwandt, 1994). This clearly differentiates positivistic and constructivist stances (Schwandt, 1999). Moreover, proponents of constructivism emphasize this ethos centers on understanding the lived experience of individuals from their perspective. Dilthey asserts

lived experience occurs within a historical social reality beyond human awareness, arguing this cannot be brought to consciousness through scientific research (Herman, 1997). Thus constructivist precepts are the basis for this two-phased qualitative research.

Accordingly, the first phase of this study examines characteristics of expert psychotherapeutic practice. Responses to this question are determined by constructivist interpretations of the researcher and psychotherapeutic trainers. As the second research phase examines what makes therapy work, responses to this question are informed by the subjectivities of West Australian expert psychotherapists and researcher understandings. Although many of these influences are tacit in nature, participants are committed to making this as transparent as possible. Thus this data is constructed rather than discovered as interpretive renderings (Ponterotto, 2002).

Judgment-Based Practice Wisdom

Judgment-based decision-making embodies a domain of knowledge distinguishable from *techne's* rationalist pragmatism. Polkinghorne (2004) argues the former embodies situationally-driven practitioner responses derived from multiple experiential events and interactions. Within the context of psychotherapy, this privileges interventions determined by context-driven therapist acumen. Thus the judgment-based practice wisdom of psychotherapy trainers and experts, canvassed in the first and second phase of this study, typifies this domain. Nevertheless, these 'coalface' understandings are at odds with positivism that endorses empirically validated treatments as the sole source of therapeutic mastery and effective interventions. Although Polkinghorne (2004) views these paradigms as a dichotomy of technical-based versus judgment-based practice, both are considered relevant to psychotherapeutic inquiry by this study. Essentially, it is suggested the implementation of these diverse epistemologies depends on situationally-positioned background requirements. The latter refers to pre-theoretical knowledge that supports individuals in their activities and decision-making (Polkinghorne, 1999). Accordingly, commentary in this chapter highlights situationally positioned

background in the context of psychotherapeutic expertise and effective interventions.

With this in mind, the first aim of this commentary presents an overview of judgment-based practitioner wisdom and its relevance to psychotherapeutic practice. Reference to the technical-based versus judgment-based dichotomy is emphasized to explain this study's rationale. Consequently, notions of explicit and tacit therapeutic knowledge and their relevance to practitioner 'know how' are explored as the next task. To advance understandings of expression of practitioner wisdom notions of cognitive, emotional and relational mastery are examined. Finally, two aspects of this practice-based paradigm are examined. These include Dewey's (1933) reflective understanding and Schön's (1983) reflective practice.

Technical Knowledge and Practice Wisdom Dichotomy

The current zeitgeist of psychotherapy privileges techne scientism as the most trustworthy source of knowledge. This is prefaced on evidence-based empirically validated techniques and adheres to scripted, sequenced strategies, experimentally proven to attain specific goals. Essentially, this implies technocratic procedures and methods facilitate effective psychotherapy and client change. Polkinghorne (2004) declares this perspective derives from techne, the ancient Greek belief that individuals are forced to develop skills that shield them from the vicissitudes of nature. In explaining this concept, Polkinghorne argues that over time, human fears of vulnerability transformed to the wish to control nature in a developing society. Increasingly, this focused on the demands of an evolving *polis* until the advent of the Enlightenment Age and its commitment to scientific rationalism. Eventually this thrust led to the last step in the development of techne, the desire to control human activity through the management and organisation of resources.

A by-product of this culture supports positivistic views of knowledge (Bernstein, 1976; Hanfling, 1981) but this ethos limits knowledge development to objective modes of theory-testing relying on experimental

procedures to establish scientific validity. As this stance asserts true knowledge of an objective reality exists outside human thought, its positivistic thrust claims this is gleaned through specific scientific tools. As only this empirical knowledge is viewed as legitimate, alternative modes of reasoning are considered inadequate for generating valid knowledge. Thus Polkinghorne contends every-day reasoning and problem-solving strategies coined “practices of care” (p. 4) are presumed inferior. Accordingly as this perspective views statements justified by positivistic research as the only form of appropriate research, a wide variety of professionals engaged in practices of care are assigned secondary status (Hoshmand & Polkinghorne, 1992). Thus this restricted view has profound implications for the thesis question that investigates the determinants of effective psychotherapy.

In view of these positivistic limitations, it is not surprising that vigorous and persuasive attacks challenge these assumptions. For instance, almost a century ago Husserl (1970) became concerned the notion of science was obscured by the dominance of objectivist conceptions. Accordingly, he attempted to expand the scientific domain so that phenomenological ideas could be viewed as an aspect of science. Moreover other critiques became evident in the philosophy of science (Kuhn, 1962; Rorty, 1979)); continental philosophy (Heidegger, 1962); philosophical linguistics (Bakhtin, 1981); social theory (Latour & Woolgar, 1986); critical theory (Habermas, 1972); feminist theory (Hekman, 1990); poststructuralist and post-modern theory (Lyotard, 1979; Foucault, 1972). While these contributions have varying emphasis, together they present a broad critique of technical rationality. Although new forms of this kind of thought continue to evolve, the most relevant to this study include Dewey’s (1933) reflective understanding, Schön’s (1983) reflective practice and Peirce’s (1955) abductive reasoning. As these constructs inform judgment-based decision-making, they pertain to the understandings of all participants in this study, the researcher and psychotherapeutic trainers and experts.

This alternative paradigm of judgment-based knowledge, with its roots in Aristotle’s (1976) *phronesis*, calls for professional decision-making by practitioners based on self-knowledge, experience and training.

Accordingly, Polkinghorne (2004) claims this implies that specific actions accomplish specific objectives with specific individuals at a specific time in a specific situation. Unlike technical based decision-making, the dictates of this paradigm centre on the person of the practitioner as the facilitator of change. Unlike the dictates of *techne*, these practitioners of care consider the needs of individuals in the context of their unique histories and backgrounds. This approach values positive outcomes over adherence to pre-determined techniques of an empiricist culture that privileges the objectivism of the randomized control trial. Contrarily, this realistic stance asserts practitioners have the capacity to glean evidence that establishes appropriate actions based on changing client needs and interests (Polkinghorne, 2000). Likewise, this form of decision-making concedes therapeutic interventions are informed by the personal qualities of practitioners who direct these actions. Thus they are required to reflect on events as they unfold and provide individually tailored responses honouring the situational circumstances of clients they serve (Payne, 2009).

As indicated in the prologue of this thesis, Polkinghorne (2004), a contemporary scholar of psychotherapy research, cites this constructivist model of embodied reasoning, contending this view of knowledge emanates from the theory-driven arguments of Aristotle's (1976) *phronesis*. Frank (2006a) affirms this *phronetic* model is a complex notion that integrates experience, acumen, and ethical appropriateness privileging these ideas as inherently dialogical and relational:

Phronetic thinking enables us to view people as feeling and concerned beings rather than as resources for stockpiling. A phronetic perspective on being with others reveals their needs and pains and calls forth a human caring response (Polkinghorne, 2004, p. 45).

Polkinghorne also argues *phronesis* is expanded by philosophers such as Dewey (1922) who posit everyday perceptions of human action are informed by background understandings. These generally operate beyond an individual's range of awareness as they are affected by changing cultural, historical and situational influences. Consequently, inquiry into these

everyday practices constitutes a potent source of “learning in situation” (p. 120). As this offers opportunities to advance existent knowledge through an alternative to empiricism, it is argued this is likely to illuminate a response to the question of what makes therapy work.

Nevertheless, as both technological and judgment-based paradigms articulate alternative views of knowledge, tensions regarding the nature of legitimate research arise. Although *techne* dominates psychotherapeutic inquiry and its concepts of empirically supported therapies and evidence based practice, considerations gleaned from the judgment-based paradigm underpin the central thrust of this thesis. This is prefaced on the understanding that psychotherapy, as a practice of care, is a social endeavour demanding inclusion of broader cultural practices that transcend the limitations of rationalist empiricism. Clearly, whether practitioners are engaged in research or psychotherapeutic care, their praxis is context-dependent. Moreover, as *techne* produces limited results, research capacities that accommodate contextual realities disregarded by empirical precepts are required. Accordingly, this position values knowledge claims gleaned from an enlarged subjective truth that reveals interactional patterns within the polis. This intersubjectivity encompasses the situational background of researcher and participant, who, at variant times, interchange their roles of knower, observer, and researcher.

Nevertheless, despite the focus of this research, this commentary concludes technically-based and judgment-based practices are insufficient in themselves. In actuality, both paradigms are needed to develop knowledge in a socially informed scientific world. Although acknowledgement of this duality is encapsulated in psychology’s science practitioner model devised at the Boulder Conference on Graduate Education in Clinical Psychology in 1949, both sides of this notion are frequently challenged (O’Gorman, 2001). Goldman (1976) suggests empirical investigation reduces assessment of therapeutic phenomena to meaningless numbers. Howard (1984) maintains positivist research is too distant from the everyday realities of practitioner work. Neimeyer (2002) points to the diversity and ambiguity in constructivist methods. Nonetheless, most

contemporary psychotherapeutic research implements tenets of empirical scientism whilst practitioner knowledge is marginalized as an alternative discourse.

Having explored the technological and judgment based polarity existing within the domain of psychotherapeutic research, this discussion turns its attention to variant forms of practitioner wisdom typifying practices of care. Although these ideas have application to a wide variety of fields such as nursing and social work, they are particularly relevant the concerns of the thesis question. Thus, the discussion that follows examines the notion of practice wisdom and its relationship with explicit, implicit, and tacit knowledge. Initially this begins with a general explanation of these notions, and then turns attention to their application within the domain of psychotherapy. Finally, the concluding stages of this chapter reveal the methodologies, methods and procedures of this study.

Significance of Practice Wisdom

Practice wisdom comprises judgment-based knowledge that evolves from experiential praxis. Despite its importance, traditionally its precepts occupy a subordinate position compared with propositional knowledge (Chu & Tsui, 2008). Additionally, ambiguous definitions of practice wisdom negate the value of this notion (O'Sullivan, 2005). Dybicz (2004) limits practice wisdom to the accumulation of information, assumptions, ideologies, and judgments useful in fulfilling the expectations of a job (p. 197). Meanwhile Specht (1977) views it as common sense that cannot be validated even when subjected to empirical investigation. Hardiker and Barker (1981) argue practice wisdom is associated with unarticulated, non-codified and undocumented understandings. Similarly, Scott (1990) equates it with tacit knowledge obtained through experience. Munro (1998) espouses it also embraces implicit use of theories absorbed during training and the making of intuitive judgements. Likewise, Krill (1990) views practice wisdom as highly personal knowledge that integrates theory, religion, philosophy, and subjective experience. Klein and Bloom (1995) look on this concept as personal knowledge that embodies a bridge between the limitations of scientific knowledge and praxis experience. However,

although these explications are diverse, they smack of a secondary status when compared with attitudes towards empiricism.

In attempting to clarify these varied meanings, Chu and Tsui (2008) posit practice wisdom is the kind of knowledge that practitioners glean from direct practice rather than formal application of theories. Essentially, practice wisdom is heuristically derived from personal reflection, deliberation, employed to identify relevant issues requiring remedial action. Moreover it also stems from reflecting and deliberating on action before adopting a specific course of action. Hence it combines espoused theories-in-action that mediate between intervention, theory and practice experience. Practice wisdom is also instrumental in applying general theories to specific contexts. This requires practitioners to combine knowledge from previous experiences with relevant theories to make sense of a new context (Fook, Ryan & Hawkins 2000). Thus two diverse images of practice wisdom emerge from these definitional attempts. The first suggests this notion constitutes an unreliable, personal, idiosyncratic domain that builds up through practice experience. Regrettably this view abounds within the scientific realm rendering its appropriateness and efficacy to be seriously questioned. However, the second view infers practice wisdom has the ability to make sound judgements in complex situations

In contrast to the traditionalist stance, the latter is adopted in this study to highlight the practice wisdom of psychotherapeutic trainers and experts. This approach values judgment-based decision-making as likely to uncover the features and informants of psychotherapeutic expertise and effectiveness. As detailed, the quest to identify these active ingredients has proved equivocal within the domain of techne. Therefore, it is hoped the explicit, implicit and tacit understandings of practitioner participants may shed light on this question. The rationale that underpins the value of this form of decision-making primarily stems from Schön's (1987) formulations of reflection-on-action and reflection-in-action.

Schön (1987) postulates reflection-on-action consists of retrospective contemplation of practice undertaken to uncover knowledge applied in

particular situations. This is achieved by analyzing and interpreting recalled information, remembering factual details as well as associated feelings and thoughts. In effect, this process centers on pondering the minutia of previous situations to ascertain how this might have been handled differently to improve outcomes. Since Schön's (1983) stressed this notion of reflective retrospection, it has become a recognised as an important method of clinical reasoning. Accordingly, Schön's understandings are a cornerstone of this study as the research populations in two phases of this study are asked to reflect on their therapeutic praxis in this way. Specifically, in the first phase of the study trainer participants are asked to ponder on their clinical praxis as well as that of skilled clinicians to ascertain the attributes and determinants of expert practice. In the second phase of the study, participants identified in the first phase of the study as as expert practitioners are asked to reflect on their practice to ascertain the qualities and shapers of effective psychotherapy.

Alternatively reflection-in-action, as defined by Schön (1987), constitutes the ability of professionals to think what they are doing while they are doing it. Schön asserts the only way to manage this 'indeterminate zones of practice' (p. 171) is through the ability to think on one's feet, applying previous experience to new situations. Schön posits that a number of elements are required to practise reflection-in-action. Firstly, he recommends a "practicum setting" (p. 37) be established for the task of learning a practice as well as the process of knowing-in-action. With this in mind, Schön asserts that "knowing is *in* the action that is revealed by skilful execution of a performance we are characteristically unable to make verbally explicit." Schön coins this process an 'action-present' as it occurs when a problem is being addressed. Secondly, Schön includes Polanyi's (1966) idea of tacit knowledge in his thesis. This consists of knowledge that is revealed when tasks are approached, derived from research, practitioner experience and reflection. Thirdly, Schön also incorporates the willing suspension of disbelief as a necessary ingredient of this process. This encompasses entering into an experience without judgment in order to learn from it. Indeed, Schön refers to this as learning by doing. Fourthly,

Schön co-opts the notion of operative attention that comprises the idea of listening and absorbing information in a state of readiness to apply and experiment this new information. This contention infers the meaning of an operation may only be learned through its performance. Hence, imperfect performance of an activity prepares the learner for new information regarding that activity to enhance understanding. Finally, Schön adopts a ladder of reflection in his rhetoric. This refers to a vertical dimension of analysis that manifests in dialogue between a learner and a teacher. To move up a rung on this ladder, necessitates reflection on an activity. Alternatively, to move down a rung involves a shift from reflection to experimentation. Additionally, Schön states this freedom of movement facilitates reflection on the actual process of reflection that promotes the resolution of 'stuck' situations in learning.

Within the context of this research, it is suggested the findings of the study are grounded in a process of reflection-in-action undertaken by the researcher. Specifically, researcher determination of overarching themes constitutes an iterative generative process. This is applied to the collaborative co-construction of research material by participant and researcher in both phases of the study. Essentially, Schön's (1983) directives on reflective practice are paramount in determining the key findings of the study. As indicated, initially participants in each phase of the research apply Schön's methodology to tap their explicit and tacit knowledge regarding the traits and influence of expert praxis and effective psychotherapy. Secondly, the researcher parallels this approach by implementing a reflection-in-action mindset to identify and articulate the findings of the study. Thus Schön's thinking is a parallel process in content and process that is foundational to the research design of the study and integral to the efficacy of its findings.

As the gleaning of explicit, implicit and tacit knowledge is the focus of this parallel process an exploration of these constructs form the next stage of this discussion.

Explicit, Implicit and Tacit Knowledge

According to Polanyi (1966), explicit knowledge embodies the most common knowledge in a form that is articulated, codified, cognitive and stored. This shares much with Ryle's (1949) 'knowledge-that' propositional, declarative, or descriptive knowledge. In essence, this concept is information made explicit by verbal or written statements. Dummett (1991) posits explicit knowledge is elicited by inquiry or prompting. Common examples in psychotherapy include text book commentary, discussion papers, research accounts, and 'schoolist' theories. Although these are exemplars of *techne*, specific contextual influences also classify them as practice wisdom. However, although Polanyi (1966) recognizes the value of explicit understandings, they are distinguished from other kinds of knowledge that are more difficult to express.

Polanyi argues (1966) that as 'we know more than we can tell' these varied phenomena are coined tacit knowledge. This embodies personal, context-specific experience deeply rooted in actions that contain emotion, values, and ideas. Furthermore, as much of this material is acquired without awareness, it is difficult to articulate or communicate. Dampney, Busch, and Richards (2002) argue tacit knowledge constitutes expertise, skill, and 'know how' in the field of knowledge management. In social work, Imre (1985) claims tacit knowledge embodies practice wisdom:

Knowledge can be seen to contain focal, or explicit content, of which the knower is clearly aware, and subsidiary, or tacit, content which is being used to give coherence and meaning to the focus which is the centre of attention (p. 139).

In describing tacit knowledge, DeRoos (1990) stresses this is process-in-action rather than end-product knowledge, suggesting it is more appropriate to refer to tacit knowledge as tacit knowing. Furthermore, although explicit and tacit information are viewed as separate domains, Polanyi (1966) contends it is more correct to view the existence of both aspects as positions on a single continuum. Leonard and Sensiper (1998) concur asserting that tacit, unconscious knowledge characterizes one end of the continuum whilst explicit, structured knowledge features at the other

end. Thus, explicit and tacit expressions are juxtaposed within a dualist framework as a synergetic relationship (Gill, 2000).

Although Polanyi (1966) is adamant that tacit knowledge cannot be transformed into explicit knowledge, the category of implicit knowledge has recently been added to this taxonomy. Specifically, Bennett (1998) argues implicit knowledge embodies an aspect of tacit knowledge when it evidences the capacity to become 'knowing that' propositional knowledge. Brockmann and Anthony (1998) contend efficiency of decision-making and accuracy of task performance in techne domains improve through implicit knowledge. Moreover, even though explicit knowledge is easier to communicate, it is often viewed as unusable without the presence of implicit knowledge (Brown & Duguid, 1998). Polanyi (1966) also asserts perception and language are the main difficulties in sharing tacit knowledge. Essentially, he maintains that although explicit knowledge is easy to recognize, feelings of intuition and missing links as exemplars of tacit knowledge are harder to pinpoint. Moreover, as individuals are generally unaware of these tacit understandings, this creates problems. Indeed, Polanyi asserts this kind of knowledge is so internalized that it becomes a natural behaviour or way of thinking.

Within the realm of psychotherapy, tacit knowledge manifests as intuition, rule of thumb, gut feelings, and personal skills. Accordingly it creates complications for knowledge classification. For instance Gore and Gore (1999) divide psychotherapeutic understandings into technical and cognitive dimensions. Technical dimensions encompass therapist expertise that equate with counselling 'know-how' whereas cognitive dimensions comprise models, beliefs, and values. Hence, these theorists perceive tacit knowledge as knowing that advances therapeutic action whilst being emancipated from technical formulas. As personal experience, reflection, internalization, and individual talents are tacit phenomena they are not managed similarly to explicit knowledge. Although the latter is stored in handbooks or information systems, tacit knowledge is housed within human beings. Thus it cannot appear in databases, textbooks, manuals or internal newsletters for the purpose of dissemination. Rather, as it is "internalized

in the human body and soul" (Haldin-Herrgard, 2000. p. 358), apprenticeship, direct interaction, networking, and action learning are identified as more suitable means to disseminate this resource. These activities incorporate face-to-face social interaction and practical experience.

Although structured, explicit knowledge plays an important role in the praxis of psychotherapy, it is argued that therapists master higher levels of tacit knowledge based on unstructured, intangible understandings that develop expertise within this domain. Indeed, Lawson and Lorenzi (1999) declare explicit knowledge typifies the skill of all psychotherapists but tacit knowledge characterizes the praxis of master psychotherapists. Thus, it becomes clear explicit expression connects closely to Ryle's (1949) 'knowing that' declarative knowledge whereas tacit understanding resembles procedural 'know how' proficiency. In recognition of the role of these tenets in effective therapy, a series of studies that examine the qualities of expert psychotherapists are reviewed. However, although the attributes of these individuals are relevant to this inquiry, it is secondary to the central consideration of this investigation that explores the determinants of effective therapy. Consequently a brief overview of the traits of master psychotherapists and their professional praxis is presented as the next task of this chapter.

Expert Praxis: Exemplar of Tacit Knowledge.

In a progression of qualitative investigations Skovholt and Jennings (2004) established the professional and personal attributions of master therapists. Their original research population consisted of ten expert psychotherapist practitioners, nominated by professional peers as 'the best of the best' in their field. Although this purposive sample ranged in theoretical orientation, education, and experience, all respondents were engaged in full-time private praxis. These studies enacted a series of complex interviews that were recorded and analyzed. Essentially, these findings led researchers to establish a set of features that characterize therapeutic mastery. Accordingly, Jennings and Skovholt organized these

traits into a sequence of cognitive, emotional, and relational qualities that typify expert praxis.

Cognitive, Emotional & Relational Expertise

Cognitive features identified by Jennings et al., (2004), suggest master therapists are voracious learners who value cognitive complexity. Moreover they draw extensively from their reflections on experience to inform their therapeutic intervention. As many of the features of cognitive mastery are ascertained by previous studies, Jennings et al., add little to these understandings. However they elicit new authoritative understandings that embody emotional and relational qualities.

Within the emotional domain, the study describes master therapists as receptive and non-defensive in their professional and personal encounters. In particular, the research establishes master therapists are keenly aware their emotional well-being affects the quality of their interventions. Consequently, Jennings et al. 2004 determine expert therapists engage in regular personal therapy and seek peer consultation and ongoing supervision. Furthermore, they value these resources as opportunities to gain heightened awareness. Moreover, master therapists strive to learn more about their emotional impact on clients. In addition, they display humility in professional and personal encounters, avoiding self-centeredness and grandiose presentations. They appear comfortable 'in their own skin', displaying modest views about their importance in the world. These studies also reveal master psychotherapists are mentally robust, congruent mature individuals who are authentic and honest (Jennings, Goh, Skovholt, Hanson, Banerjee-Stevens, 2003; Jennings, Hanson, Skovholt & Grier, 2005; Jennings & Skovholt, 1999; Skovholt et al., 1997).

The third domain identified by Jennings et al., (2004) asserts that expert psychotherapists possess highly developed interpersonal skills. Invariably, this research concedes these skills stem from early life experiences within their families of origin. Specifically, these investigations reveal master therapists develop exceptional relational skills by listening to

and observing others early in life. Moreover, Jennings and Skovholt (1999, 2004) ascertain master therapists believe the foundation for restorative change lies in dedicated therapeutic relationships, prefaced on caring for others. In addition, this research ascertains the emotional wounds of expert therapists increase their sensitivity and compassion towards others. Finally, master therapists display strong social skills that empower them to discuss painful subjects with clients, challenging them when necessary.

Having reviewed much of the relevant explicit and tacit knowledge that characterizes judgment-based practice wisdom, the final exploration of this domain examines the notion of reflection as an integral feature of this paradigm. As this builds on Dewey's (1933) notion of reflective understanding, Schön's (1983) reflective practice and Peirce's (1955) abductive reasoning, these constructs are examined in terms of their relationship to the thesis question.

Reflexive Praxis

Although reflection is a hackneyed epithet privileged by diverse domains within the postmodern literature, the protocols of reflective praxis remain woolly and vague. Within the realm of teaching, Boud, Keogh, and Walker (1985) define reflection as an intellectual activity enabling individuals to explore experiences and attain new understandings. Alternatively, from a nursing perspective, Reid (1993) claims reflection is a process of reviewing experience to describe, analyze, evaluate and inform learning about practice (p. 3). Likewise, Kemmis (1985), in the field of higher education, states reflection embodies a positive active process that reviews, analyses and evaluates experience. Finally, Johns (1995) brings a medical stance that notes reflection enables practitioners to assess, understand and learn through experience. However, although these definitions espouse similar ideas, they fail to detail the specific procedures that constitute the actual activities of reflection. Yet, as the research design of this thesis centers on the reflections of expert psychotherapists, this discussion asserts a clear understanding of these components is essential. Consequently, this commentary turns its attention to a detailed analysis of Dewey's (1933) reflective understanding, Schön's (1983)

reflective practice and Peirce's (1955) abductive reasoning as authorities on these procedures. Given the nature of this research, their perceptions are viewed as substantive influences on its methodological design.

Dewey's Reflective Understanding

Nearly one hundred years ago Dewey (1933) identified several modes of thought that include belief, imagination, and streams of consciousness. Nonetheless, perhaps his most significant input focuses on the process of reflective inquiry. While many scholars contend Dewey's thoughts augment practitioner research, there is general support for the view that reflexive praxis constitutes his major contribution (Schön, 1983). In examining Dewey's ideas, Rodgers (2002) distils four criteria that inform his thinking. As these have relevance to practices of care such as counselling and psychotherapy, a brief overview of these notions is presented.

Firstly, Rodgers (2002) claims Dewey (1933) considers reflection to be a meaning-making process that moves from one experience to another whilst gaining a deeper understanding of the nexus between these encounters. Thus this movement, intrinsic to reflective inquiry, constitutes a substantive thread that makes the continuity of learning possible. Dewey argues this ensures individual and societal development that highlights interaction and continuity. With regard to interaction, Dewey (1933) asserts any experience implies the existence of an interaction between oneself and the world that guarantees the presence of change in self, the other, and the environment. In regard to continuity, this dialectic has implications for the learner, the other and the world. Specifically, individuals make sense of new experiences based on meanings gleaned from prior personal occurrences and knowledge of others.

Secondly, Dewey (1933) views reflection as a systematic, rigorous, disciplined thought process, rooted in scientific inquiry. In particular, this phenomenon is understood as the "active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusion to which it tends" (p. 9). Thirdly, Dewey (1944) argues reflection takes place within a community

that ensures interpersonal interaction. Hence, thinking without expressing to another constitutes an incomplete act as statements to others reveal strengths and weaknesses in individual thinking. Accordingly, he stresses reflection incorporates the following actions:

To formulate requires getting outside of [the experience], seeing it as another would see it, considering what points of contact it has with the life of another so that it may be got into such form that he can appreciate its meaning. . . . One has to assimilate, imaginatively, something of another's experience in order to tell him intelligently of one's own experience. . . . (p. 6)"

Moreover, Dewey's (1933) awareness of the affective dimension of reflection leads him to stress its role in learning. In essence, he underscores that attitudes an individual brings to bear on reflection are thought to open or block learning. Thus Dewey construes an awareness of emotions coupled with the discipline to harness them are essential features of constructive thinking.

In reviewing Dewey's (1933) ideas Polkinghorne (2004) infers reflection informs the judgments of experts in a variety of disciplines. Schön (1987) also argues reflective understanding differs from rational-technical thinking that is based in conscious deductive thought. Although practitioners use inferential thinking to apply scientifically validated knowledge, this contrasts with reflexive praxis that incorporates tacit background effects. Thus reflexive action acknowledges out-of-awareness, non-conscious processes constitute a great many aspects of therapeutic praxis. In particular, reflective understanding draws on internalised knowledge to realise goals. Essentially, this embodies an active process of decision making that adds to background knowledge. Indeed practitioner reflective understanding constitutes a dialogic engagement with a specific situation that leads to the enactment of a number of practices. Accordingly these actions lead to increased knowledge of a situation as it unfolds (Polkinghorne, p. 163). As Dewey's (1933) ideas have particular relevance to the field of education, Schön (1983) expands many of these ideas to the realm of practitioner judgment. As current research, psychotherapeutic

studies, and scholarly literature view Schön's ideas as authoritative, his conceptualisations on reflective practice are relevant to concerns articulated by the thesis question.

Schön's Reflective Practice

Although Schön's (1983, 1987) theories were articulated more than three decades ago, they retain unprecedented popularity within the multi-dimensional discourses of health and the social sciences. Moreover, in the field of education, Eraut (1995) asserts Schön's ideas on professional expertise are highly regarded. Furthermore, Gilroy (1993) alleges all of Schön's concepts are influential with trainers and educators from diverse professional fields. Kinsella (2007) argues reflective practice is the dominant model of postgraduate higher education together with medical and health instruction in the United Kingdom. In examining the impetus for Schön's (1992) success, critics contend practitioners resonate with these views as they often reflect their own beliefs that are too fearful to be revealed (Bleakley, 1999):

When practitioners accept and try to use the academy's esoteric knowledge, they are apt to discover that its appropriation alienates them from their own understandings, engendering a loss of their sense of competence and control (p. 120).

Specifically, this acknowledgement that science and technology do not answer the problems of practice is well-received by diverse professional practitioners as it gives legitimacy to the everyday dimensions of practice that ground scientific evidence. Furthermore, it affirms that practice reflexivity embodies a valid approach to professional development. Indeed Kinsella (2007) contends reflective practice assists professionals to re-frame issues of complexity that transcend the dominant emphasis on scientific discourse (p.103). Commentators also identify links between the critique of positivism and the legitimacy of practitioner experience as a rationale that underpins the rise of reflective practice. Taylor and White (2000) suggest this popularity stems from an emphasis on the minutiae of day-to-day praxis

in lieu of the implementation of technical knowledge. In this way, reflective practice is said to deal with real-world issues identified by practitioners.

Essentially Schön (1983, 1987) investigates reflective understanding in the context of practitioner judgment and states individuals engage in reflective practice when their background-informed practices are insufficient to achieve specific goals. Dewey (1933), who originated this notion, argues human beings do not experience objects in the world as isolated encounters. Contrarily, he posits they are reviewed through a situationally contextualized interactive process. Thus events are layered and textured by an iterative, generative interconnection amongst all its parts. With this in mind, Schön (1983) postulates that when background ideas fail to satisfy practitioners, the phenomenon of reflection occurs. This takes two forms: reflection-in-action and reflection-on-action. Reflection-in-action occurs when individuals 'think on their feet', by taking account of their experiences, feelings and theories. This facilitates new understandings that inform actions within a situation that is in the process of unfolding:

The practitioner allows himself to experience surprise, puzzlement, or confusion in a situation which he finds uncertain or unique. He reflects on the phenomenon before him, and on the prior understandings which have been implicit in his behaviour. He carries out an experiment which serves to generate both a new understanding of the phenomenon and a change in the situation (p. 68).

These actions enable practitioners advancing actions to break and step back from them to contemplate their appropriateness. Moreover, this process of reflection-in-action links with a secondary activity coined reflection-on-action occurring after completion. With this in mind, Polkinghorne (2004) argues Schön's (1983) notions of reflection-in-action and reflection-on-action parallel Dewey's (1933) reflective understanding. Accordingly, Schön urges practitioners to test theories to facilitate future practical responses. Interestingly, Schön, like Dewey, encourages

practitioners to abandon established pre-formed ideas driven by technical rationality:

When a practitioner makes sense of a situation he perceives to be unique, he sees it as something already present in his repertoire. To see this site as that one is not to subsume the first under a familiar category or rule. It is, rather, to see the unfamiliar, unique situation as both similar to and different from the familiar one, without at first being able to say similar or different with respect to what. The familiar situation functions as a precedent, or a metaphor, or... an exemplar for the unfamiliar one (Schön 1983, p. 138).

Dewey and Schön argue that as individuals engage with a situation, they are influenced by previous events. Hence they draw on routines in the here-and-now and in the future, supported by their repertoire of skills. Accordingly, fragments of memories build on responses to fit new situations. In describing this process Schön (1988) postulates:

When someone reflects-in-action he becomes a researcher in the practice context. He is not dependent on the categories of established theory and technique but constructs a new theory of the unique case...he does not keep means and ends separate, but defines them interactively as he frames a problematic decision which he much later must convert to action...Thus, reflection-in-action can proceed, even in situations of uncertainty and uniqueness, because it is not bound by the dichotomies of technical rationality (p. 76).

Despite the unprecedented success of Schön's (1983) ideas, they share much in common with Dewey's (1933) critique of technical rationality. Furthermore, Schön's constructs provide significant opportunities to advance practitioner professional development. Although these individuals engage in practices of care, they rarely have the opportunity to participate in scholarly conversations. Thus notions of reflection-in-action and reflection-on-action provide practitioners with a

language that enables them to participate in professional development conversations. Indeed Kinsella (2007) makes the point that the popularity of Schön's (1983) notion of the reflective practitioner stems from this tension. She posits that professional practitioners are caught in a gap between their experience of practice and the limitations of technical rationality. Consequently, they are relieved to discover that reflective practice acts as a foil to technical rationality's insistence that scientism is the only way to grapple with their problems. Interestingly, Eraut (1995) notes publication of Schön's (1983) work coincides with a growing disillusionment about the role of science directed at the North American academy where positivism traditionally retains a strong footing. However, although the latter is popular in English-speaking countries, it has failed to acquire this position in Europe. Nonetheless Polkinghorne (2004) points out that the technical-rational approach to decision-making continues to be normative in professional life in Western society.

By way of contrast, Schön's (1987) discourse questions this dominance, acknowledging the complexity and challenges of applied praxis that *techne* ignores. This view is consistent with Newman's (1999) critique asserting technical rationality "ignores or violates actual experience" (Searle, 1969, p. 45). Nonetheless, while Dewey's reflective understanding and Schön's (1983) reflective practice embody significant features of practice wisdom that inform the philosophical basis of this study, they are insufficient in themselves. Accordingly, as Peirce's (1955) abductive reasoning constitutes a major device for reflecting on tacit knowledge and problem solving, this pragmatic notion is worthy of discussion.

Peirce's Abductive Reasoning

Peirce's (1955) abductive reasoning informs Bishop's (2007) statement that "positivism in mainstream psychology led to the belief that research can result in certainty about an uncertain world" (p. 12). Essentially, Peirce posits logic that provides tentative knowledge about tentative phenomena is legitimate. Initially, Peirce explained abductive reasoning as the process of studying ideas leading to emergent theories

explaining their legitimacy (Cunningham, 1998, p. 833). Denzin (1978) defines this as:

Working from consequence back to antecedent... the observer records the occurrence of a particular event, and then works back in time in an effort to reconstruct the events (causes) that produced the event (consequences) in question (p.109-110).

In attempting to convey the meaning of this concept, theorists argue abductive reasoning is a logical inference that resembles the colloquial 'hunch' (Shank, 1998; Ward & Haig, 1997). This manifests when researchers contemplate a series of seemingly unrelated notions and then become aware, through their intuition that these are somehow connected (Cunningham, 2002). Essentially, an abductive enactment is the actual process of inference that produces an end result that resembles a hypothesis. It is the process of facing an unexpected fact, applying a rule, and positing a specific supposition is correct (Johansson, 2004). Thus a precondition is inferred from its consequence.

Moreover Peirce (1955), the founding father of American pragmatism, contends abductive reasoning is a pragmatic inference that is distinguishable from induction and deduction, the other forms of theory generation (Richardson & Kramer, 2006). Ezzy (2002) defines deductive theories as conceptualisations derived from general propositions drawn from a specific statement. These move from a general to specific cases whilst inductive theories move from specific observation to generalized empirical data collection. Thus Peirce (1955) contends abduction creates new ideas through the creation of new hypotheses. Rennie (1998a) asserts it represents "any form of a new idea, including intuition and hunches" (p. 111) whilst Davis (1972) describes abductive logic as "a creative leap of the mind" (p. 4). This occurs when individuals suddenly understand how a particular event fits into a broader picture of explanation. This approach does not use pre-existing theories, but, conversely, informs the observation process by suggesting general social processes or 'rules' apply. These are then tested through rigorous deduction and induction (Charmaz, 2008). In describing abduction Ezzy (2002) postulates it fosters imaginative leaps

towards new theories which explain prior observations. Essentially, Peirce declares it “depends on our hope, sooner or later, to guess at the conditions under which a given kind of phenomenon will present itself” (Sebeok, & Umiker-Sebeok, 1983, p. 2). Interestingly, Patton (2002) argues this resembles detective work as abduction compares possible explanations against a few facts to arrive at a larger picture that explain a course of events. Although emergent theories appear to conflict with existent or obvious explanations, abductive reasoning accepts this inconsistency and ambiguity as normative. As Eco (1983) submits, the major thrust of abduction embodies “the courage of challenging without further tests, the basic fallibilism that governs human knowledge” (p. 220). Peirce (1955) also insists the discovery of new understandings occurs when abduction, followed by induction and deduction, embodies a complex process of inference, insight, empirical observation and logical reasoning. In addition, the shuttling back and forth between general propositions and empirical data is central and encourages theory development (Richardson & Kramer, 2006).

In explaining abductive logic, Schumacher (2008) suggests researchers move dialectically, between observation and conceptualisation, during data analysis. Accordingly, this recursive, generative action creates conditions for the emergence of flashes of insight that spring new knowledge (Clarke, 2008; Reichertz, 2007). Consequently, speculative claims develop by drawing inferences from logical combinations of hypothetical information. This method uses abduction, induction, and deduction at different stages of inquiry. According to Cunningham (1998) abduction is the appropriate method for making sense of new situations. In addition, Bateson (2002) contends “all thought would be totally impossible in a universe in which abduction was not expectable” (p. 134).

Like Dewey’s (1933) reflective understanding and Schön’s (1983) reflective practice, Peirce’s (1955) abductive reasoning contributes significantly to this study. Specifically, this notion comprises a substantive mode of reflection undertaken by both researcher and participant in both phases of the research. This contributes substantively to the study’s

meaning-making procedures. In particular, the collaborative nature of participant and researcher explorations regarding the determinants of effective therapy necessitates a dialectical process of abductive reasoning in data gathering and analysis. Accordingly, the initiators of emergent assertoric knowledge recognize that subjective understandings cannot be separated from those who voice it (Bishop, 2007). Indeed, hunches and intuitive speculation of researcher and participant instigate flashes of insight. Accordingly, these 'light-bulb' moments, particularly in the study's second phase, 'uncover' tacit wisdom of expert psychotherapists. Accordingly this illuminates responses to the thesis question.

Furthermore, the abductive reasoning implicit in this study demonstrates that knowledge based on tentative evidence plays a significant role in the development of new knowledge. Essentially, it subjectifies the research process that is perceived as mixing the researcher with data analysis and theory development in dynamic social contexts (Bishop, 2007). As the evolution of assertoric knowledge relies on practical reasoning, decision-making informed by these processes is based on uncertain alternatives. Consequently, this does not constitute true knowledge for all times and places, but merely serves as a basis for action. This contrasts with deductive logic that requires the attainment of absolute certainty. Alternatively, researchers who strive for assertoric knowledge draw on argumentation without the assurance of knowledge certainty. Hence, an abductive researcher tolerates doubt and ambiguity as authentic features of multiple social realities that constitute a changing, uncertain world. Thus as Bishop and Browne (2006) stress, abductive reasoning "frees us from the 'rigours' of logical positivism yet recognizes the importance of community understanding" (p. 7). It also privileges collaborative, shared knowledge rather than the more competitive thrust of psychological science.

Having reviewed the ontological and epistemological tenets that inform the research design, the third level of methodological design implemented by this thesis is explored. As this domain invariably fuses with

the fourth level of methods and procedures, the following commentary addresses these levels consecutively to facilitate economy of words

Methodology, Methods, and Procedures

As this thesis aims to uncover the informants of effective therapy from the understandings of West Australian expert psychotherapists, inquiry centers on the gleaning of practitioner wisdom. Consequently, exploration is confined to methodologies, methods, and procedures derived from the paradigm of judgment-based practice. As this takes the form of explicit, implicit, and tacit therapist knowledge, relevant methodology is qualitative and phenomenological in design. The study adopts a contextualist view of knowledge that highlights its social constructionist thrust. Moreover these attributes are supported by a variety of methodologies that include substantive theorizing, grounded theory, hermeneutics and critical reflexivity. As these contribute to the practical implementation of this study, these methodological theories are examined together with the methods and procedures that give effect to these constructs.

Qualitative Exploration

Although a plethora of authorities define qualitative research this commentary endorses Polkinghorne's (2005) ideas. He asserts qualitative inquirers aim to "build a complex and holistic picture of human experience as it appears in peoples' lives" (p. 137). Denzin and Lincoln (2005) conclude this is a situated activity that locates the observer in the world of the research. Accordingly, they stress this form of exploration consists of interpretative, material practices that make this world visible. Alternatively, Patton's (1984) explication that these efforts support processes used to understand, appreciate and portray meaning-making is also useful. Nevertheless, despite the relevance of this form of inquiry to the domain of psychotherapy, qualitative inquiry did not find acceptance within the psychological realm until relatively recently (Morrow, 2007). Despite this resistance McLeod (2001) makes the point that psychotherapeutic researchers like Elliott (1984) and Rennie (1994) have kept qualitative research alive by borrowing methods from other disciplines

to investigate outcome and process effects. Moreover, qualitative research is gradually gaining greater prominence within psychology as it offers opportunities to explore issues in-depth (Miles & Huberman, 1994; Strauss & Corbin, 1990; Willig, 2001).

As this study aims to glean the understandings of West Australian psychotherapeutic trainers and expert therapists, it falls within the ambit of qualitative research. Specifically, elicitation of tacit, implicit, and explicit understandings of these research populations forms the focus of investigation. As this aims at rich descriptions of practitioner wisdom (Fishman, 2000) varied methodologies and stances are utilized. However, prior to addressing discussion these constructs in the context of the thesis question, it is helpful to provide a broad overview of the structure of this study.

Two-Phased Study

Essentially, this inquiry aims at uncovering practitioner wisdom with regard to the informants of effective psychotherapy. To maximize this objective, the study was organized into two distinct phases. The first phase consisted of interviews with thirty-two West Australian psychotherapeutic trainers who facilitate the instruction of diverse forms of therapeutic modalities. During these interviews participants completed two separate tasks. Firstly, they were asked to comment on the meaning of expert psychotherapeutic practice through a semi-structured interview process. Accordingly, thirty-two one hour interviews with psychotherapy trainers and educators were completed. Secondly, each interviewee nominated three West Australian expert psychotherapeutic practitioners they considered experts in their field. As a result ninety-one 'blind' nominations of expert practitioners were cast. As many of these practitioners were nominated on numerous occasions, a master list of fifty-nine psychotherapeutic practitioners was compiled. Consequently, practitioner names that appeared three or more times on the master list were deemed expert psychotherapeutic practitioners for the purposes of second phase of the study. Accordingly, nine psychotherapeutic practitioners fell within this classification.

During the second phase each of the nine expert psychotherapist nominated by this process participated in a series of conversational interviews. In these conversations the researcher explored respondent understandings regarding the determinants of effective psychotherapy. As each of these phases were informed by phenomenology, hermeneutics, social constructionism, substantive theorizing, and critical reflexivity, the next task of this discussion explores each of these methodologies and their implementation in this research design.

Phenomenological Considerations

Phenomenology, developed by Husserl (1960), conveys the unique essence of a phenomenon from the subjective, first person viewpoint of individuals who are exposed to this phenomenon (Moran, 2000). To attain this goal, qualitative researchers observe an object of human experience (McLeod, 2001). Over time they collect data from the research population that encounters this phenomenon. Finally, the inquirer develops a composite description of its essence based on what the respondent population experienced and how they experienced it (van Manen, 1990).

Although this method of inquiry derives from assumptions that underpin the disciplines of sociology and anthropology (Spiegelberg, 1982), this approach gained popularity within the psychological domain by the end of the twentieth century (Giorgi, 1985; Polkinghorne, 1989; Smith, 1996). These diverse domains conceptualize phenomenology similarly with common elements that include i) recognition that phenomenology studies lived experience; ii) these experiences are conscious events that iii) lead to descriptions of essence (Moustakas, 1994).

Application of Phenomenology

As phenomenological investigation explores subjective experience (Moran, 2000), this methodological orientation constitutes a major feature of this research. Its application is determined by the major thrust of the study, the exploration of the subjective understandings of expert psychotherapeutic practitioners with regard to what makes therapy work. This approach is selected on the basis that it is likely to glean rich

descriptions of participant wisdom in the form of explicit, implicit and tacit knowledge. Specifically, phenomenological data provides extensive declarative and procedural knowledge regarding the attributes of expert praxis and the determinants of effective therapy. Although phenomenology represents an important strategy of this research, the related discipline of hermeneutics is also pertinent.

Hermeneutic Considerations

Initially the practice of hermeneutics, developed by Gadamer (1975) was confined to the interpretation of written 'texts' in specific contexts such as literature, religion, history and law (Radnitzky, 1970). However, qualitative research gradually extended this notion to apply to any human act that requires interpretation. Specifically, hermeneutic investigation emerged through the implementation of repetitive interpretation. This recursive stance manifests as repetitive movements that cycle back and forth between part and whole of a text. This involves a series of iterative generative steps that focus on recurrent interpretation of meaning within the body of the text. Although hermeneutic inquiry demands procedural rigour, it depends upon sensitive interpretation of the emotional and interpersonal worlds of a research population. As these procedures generate texts in the context of cultural and historical traditions, the hermeneutic researcher constitutes a subjective interpreter whose beliefs and prejudices inform interpretation of texts. Thus, hermeneutics evidences the co-construction of understandings by the researcher and the researched (Cushman, 1990). As Kvale (1996) concedes, "interpretation goes beyond the immediately given as it enriches the understanding by bringing forth new differentiations and interrelationships in the text extending its meaning" (p. 50).

Application of Hermeneutics

A number of considerations were addressed in the hermeneutic implementation of this research. Firstly, all perspectives offered by the respondent population in both phases of the study were recognized. Accordingly, data presented by both psychotherapy trainers and expert

practitioners was subjected to this process. Secondly, investigation moved back and forth between the whole and parts of elicited data. This related to the question of expertise in the first phase and the determinants of effective psychotherapy in the second phase of the study. Thirdly, these notions were examined with reference to the literature review outlined in previously. Finally, all contextual factors embedded in the research environment within conscious awareness were included in researcher/participant interpretations. In particular, attempts to include researcher interpretations regarding emergent data, the elicitation process, and the practical conditions that influenced text development were undertaken.

While phenomenology and hermeneutics are qualitative forms of research that determine the meaning of personal experience, they generally focus on individuals (Loseke, 2003). Although these modes of investigation examine contextual factors, they do not focus on the multiple realities that individuals construct through their social activities (Burr, 1995). Accordingly as this study is interested in these dynamics, it adopts a social constructionist stance to examine these multiple realities.

Social Constructionist Stance

Social constructionism embodies a sociological position that examines how phenomena, known as social constructs, develop in specific contexts. Essentially, social constructs are viewed as products of human choice rather than practices derived from divine will or nature (Burr, 1995). Even though social constructs appear to be natural occurrences, they constitute artifacts of a specific culture. Although the meaning of social constructionism is broadly interpreted, Berger and Luckman (1966) and Gergen (1985) are considered its leading exponents. Even though these authorities contend social constructionism stems from the competing domains of social hermeneutics (Gadamer, 1975) and post-structuralism (Foucault, 1980) there is common agreement on its key characteristics (McLeod, 2004).

The central idea of social constructionism rests on the belief that all human beings act together. Hence social constructionist inquiry examines

how people within a community act together. This leads to further questions that inspect ways this joint action is accomplished. Typical social constructionist research aims at discovering sources of power and control that facilitate this joint action. To attain this understanding researchers explore power dynamics within specific settings that investigate who has control of it and how it is exercised. Moreover researchers look at the role of language when people act together and its relationship to societal power and control. As these questions focus on the collective generation of meaning, they embrace the ethos that knowledge is never objective (Bohan, 1990). Instead, social constructionists view reality as a subjective process informed by human perception and interpretation. This stance stresses reality is never a direct reflection of an objectified environment. Instead it is a social phenomenon, created, institutionalized and transformed into a representation of a particular culture (Willig, 2001). As the major focus of social constructionist research seeks to uncover how individuals create their social world, its findings authenticate the existence of multiple forms of subjective knowledge. Moreover, this perspective views knowledge development as an ongoing, shared dynamic. Specifically, social constructionist research focuses on the collective efforts of researcher and those researched to generate co-constructed data, mediated by both parties who are embedded in the inquiry (Gergen, 1994).

Within the domain of psychotherapy, research traditionally reflects the natural sciences paradigm and its ethos of positivism (Burr, 1995; Fine, 1994). This approach centres on the individual whilst diminishing the importance of cultural factors. As these objectivist studies are designed to 'control for' and eliminate 'extraneous variables' contextual factors are removed. However psychotherapeutic authorities increasingly acknowledge this individualized approach reinforces disconnection and separateness. Indeed McLeod (2004, p. 353) postulates this focus on autonomy and self-sufficiency has the potential to become destructive as it shifts individuals towards states of isolation. With this in mind, scholars suggest this modernist psychotherapy discourse, concerned with the structure of the individual self, is gradually being supplanted by a postmodern discourse of

relatedness (Cushman, 1990). A pivotal move of this refocusing process marks the shift from abstract relational structures such as interpersonal schemas towards a relatedness that occurs between actual people on an everyday basis (Sullivan, 1953). Viewed in this light, therapy becomes a course of action that empowers people to build meaningful communities that work together for a common good.

In keeping with this shift from an individualized stance to a socio-cultural perspective, social constructionism privileges exploration of contextual features prefaced on the presence of subjectivity and relationship. Unlike modernist psychotherapy this stresses the “primacy of relational, conversational and social practices as the source of individual psychic life” (Stam, 1998, p. 199). Indeed, McLeod (2004) views counselling and psychotherapy as a cultural arena in which people experiencing difficulties may re-construct a sense of personal agency. Nightingale and Cromby (1999) argue that as this form of reality is socially negotiated, it contrasts with the more isolated forms of personal knowing that characterize the history of Western psychotherapeutic ideas (Sampson, 1989). Accordingly, social constructionist psychotherapists concerned with notions such as emotion (Harré 1986), prejudice (Potter & Wetherell, 1987) and psychopathology (Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995) assert these concepts constitute ways of constructing reality rather than reflecting it.

Application of Social Constructionism

This project incorporates social constructionist ideas, informed by the subjective co-constructions of the researched and the researcher (Gergen, 1994). Specifically, these co-constructions are embedded in the multiple subjective realities of psychotherapeutic trainers in the first phase and psychotherapeutic experts in the second phase. However this participant experience was also mediated by the subjectivity of the researcher, a psychotherapeutic practitioner.

Specifically, in the first phase participants and the researcher examined the professional artifacts of West Australian psychotherapy

trainers with regard to the attributes of expert practice. In the second phase, the researcher and West Australian peer-nominated expert psychotherapists established negotiated understandings regarding the identification of influences that make therapy work. As these insights became apparent through collaborative unstructured conversations, all parties recognized that language played a significant role in the elicitation of data. This emerged as cultural artifacts in the form of explicit and tacit professional knowledge. In particular, the principal goal of the study aimed to generate new, declarative knowledge concerning the determinants of effective psychotherapy. This was achieved principally by transforming expert therapist procedural knowledge to propositional information. As this study aimed to extend theoretical understandings with regard to what makes therapy work, it also drew on the notion of substantive theorizing to advance the development of new psychotherapeutic concepts. This approach comprises an ecologically-oriented stance aimed at the establishment of contextually-driven knowledge that differs from the approach of traditional empirical inquiry.

Substantive Theorizing

According to Wicker (1989) research occurs within three different domains. The conceptual domain represents the theoretical concepts and hypotheses that relate to any phenomenon under review. The second realm of methodology represents techniques for gathering information for analysis, whilst the third realm, the substantive domain, refers to the phenomena of interest as it exists within the social and physical world. In reflecting on these domains Wicker and August (1995) suggest different forms of research place different emphases on each of these realms. For example, psychological researchers traditionally attach greatest significance to the conceptual field. Moreover they generally allot secondary status to methodology whilst the substantive domain is often ignored. Consequently this approach results in the expansion of experimental research characterised by top-down, theory-driven design protocols that test hypotheses in the researcher's chosen context (Brinberg & McGrath, 1985). Thus Seidman (1989) criticizes this stance asserting it

marginalizes bottom-up, generative, discovery-oriented research. Indeed Wicker (1989) encourages psychological researchers to expand their horizons by placing greater emphasis on the substantive domain that encourages exploratory research.

Application of Substantive Theorizing

In keeping with Wicker's (1989) recommendations, this study enters the substantive domain of psychotherapy to investigate the understandings of trainers and expert psychotherapists. This investigative stance differs from the majority of psychotherapy studies that expand the methodological domain whilst ignoring substantive and conceptual spheres. The privileging of randomized control trials and meta-analyses that validate evidence-based practice evidences this thrust (Seidman, 1989; Wandersman, Hallman, & Berman, 1989). However the thesis question breaks with this dominant trend by directing primary research attention to exploration of tacit practice-based knowledge. Accordingly, this directive highlights the substantive domain of practitioner understandings with regard to therapeutic effectiveness and mastery. These evolve from interactions within the social and physical world of this cohort (Wicker & August, 1995). As exploration taps tacit, procedural knowledge of expert practitioners beyond their range of awareness, this transforms covert material into overt declarative knowledge (Polanyi, 1958). Moreover, discussions that address overt understandings regarding the informants of effective therapy strengthen emergent explicit knowledge (Davidson, 1989). Furthermore, these perceptions are analyzed pursuant to Wicker's (1989) dictates. This enriches the conceptual domain of this phenomenon, developing new theories with regard to what makes therapy work. Although augmentation of the methodological domain through empirical assessment is beyond the scope of this thesis, this mode of investigation may be operationalized in future investigations that build on the findings that emerged from this study. In view of the epistemological importance of Dewey's (1933) practitioner wisdom, the methodological primacy of critical reflexivity cannot be denied. However, as this postmodern concept is shrouded in

confusion by terms such as reflective praxis, initially attempts are made to clarify the nature of this notion.

Critical Reflexivity

Although definitions of critical reflexivity abound, they are ambiguous and fuzzy. Alvesson and Sköldberg (2000) describe critical reflexivity as reflection characterised by careful interpretation. They claim this practice directs attention inwards towards the personhood of the researcher, the relevant research community, its intellectual and cultural traditions, language use and society as a whole. Thus this approach to critical reflexivity defines it as the interpretation of interpretation. In effect, this views critical reflexivity as a critical self-exploration of one's own interpretations (Alvesson & Sköldberg, p.10).

Implementing a different approach Freshwater and Rolfe (2001) simplify this concept, stating that it constitutes inquiry that "turns back on itself" (p. 531). To clarify the meaning of this phrase they identify three distinct features of this notion. The first acknowledges reflexivity embodies reflection on the actual process of reflection. Secondly, Freshwater and Rolfe espouse critical reflexivity incorporates introspective pondering of social and political context. This invites researchers to contemplate complex ideological and political agendas hidden within research (Richardson, 1994). Thirdly, they perceive reflexivity is reflection-in-action that occurs as the actual process of research takes place. Finally, Freshwater and Rolfe claim the common denominator amongst all these features demands investigators remain open to maintaining a critical stance to their praxis. Thus critical evaluation is intrinsic to all aspects of reflexivity. Alternatively, Derrida (1976) suggests researchers engage in critical reflexivity that 'turns back' on all expressions of text. Essentially, this position states all research texts embody fabrications of truth. Accordingly, this in itself constitutes a social construct. Thus, researchers are required to subject all texts to the praxis of deconstruction. As Fox (1993) states:

Research texts, like any others, are to be read and re-read, not as representations (accurate or flawed) of the world, but as contested claims to speak the truth about the world, constituted in the play of disciplines of the social. Research writing, in this model, becomes narrative work (p. 531).

A critically reflexive approach challenges the traditional view of scientific research as an objective window that looks upon a truthful external reality. Instead, it constructs empirical research as a singular truth existing among many diverse truths (Lyotard, 1979). This stance positions research as opportunities to narrate stories about lived experience rather than the ability to present a synthesized, singular reality. Thus critical reflexive ideas reject the view that research may be 'controlled' in ways posited by the scientific empirical paradigm. They view research as a local practice that produces contingent knowledge that is always subject to critical scrutiny and evaluation (p. 531).

Within the domain of psychotherapy McLeod (1999), postulates critical reflexivity requires investigators to gain an awareness of their contribution to the construction of meaning in any research process. This acknowledges researchers are unable to remain outside the subject matter of their inquiry and urges them to determine how their involvement affects their investigations (Nightingale and Cromby, 1999, p. 228). Consequently, researchers are obliged to reflect on data elicitation processes in a transparent manner, recognizing their aims, values, experiences, and beliefs inevitably shape their findings. Malterud (2002) argues researcher background and position determines what researchers investigate, their angle of investigation, methods and framing of conclusions. Moreover, Glesne (1999) asserts critical reflexivity is essential as researchers, themselves, are the primary instruments of data collection and analysis. Consequently, theorists such as Russell and Kelly (2002) contend critical reflexivity empowers researchers to be aware of what empowers them to determine findings, as well as what inhibits this. Indeed, Hertz (1997) claims when researchers are reflexive they engage in ongoing internal

conversations with experience. Yet at the same time, they live in this experience and observe it through the research praxis.

Application of Critical Reflexivity

This research adopts a critically reflexive position informed by the ideas of McLeod (2001) that reveals issues often overlooked by empirical research. In particular, awareness this thesis is an interpretative endeavour that utilizes critical reflexivity ensures interpretations are made as transparent as possible. Furthermore, the process of turning a critical eye on researcher assumptions is paramount. Accordingly, this is likely to make the study more trustworthy. Indeed, throughout the research journey the prejudices and personal involvement of the researcher are apparent in the reflexive prologue and epilogue included in this thesis. In particular, the reflexive and epilogue of this thesis utilizes critical reflexivity to explain why this investigation was undertaken. This takes the form of a personal discourse that explains the rationale that underpins the development of the research question. Evidence of critical reflexivity is also found in the construction of textual material intrinsic to the research itself. Accordingly, these are detailed in the procedural section described later in this chapter. Finally, the reflexive epilogue provides an overview of the researcher's personal response to the findings of the study.

Methods and Procedures: Constructivist Bricolage

As indicated, the methodological complexity of this study manifests in two distinct phases. Thus commentary that follows outlines methods and procedures used in each of these phases. As this description parallels the sequential development of the study, details of participant criteria, collection and analysis of research material are included. As these initiatives represent the fourth level of design, this discussion concludes comments on the study's methodological design. Accordingly, the next task of this discourse examines the nature and role of methods in qualitative research.

Meaning of Method

King (1994) defines methods as the process of “listening to... informants, observing behaviour, examining historical traces and records” (p. 19). Alternatively, Bowles (1983) postulates methods function as the means to help researchers ascertain what they need to know. Essentially, methods gather information that provides answers to actual research questions. Du Bois (1983) contends these differ as they depend on the epistemological perspective and level of theoretical development of the research question. Harding (1987) stresses strategies that realise methods on a step-by-step basis are commonly referred to as procedures. As the design of this study is varied and multi-dimensional, methods and procedures to implement this blueprint are diverse. As a series of complex strategies and techniques were implemented to realise the objectives of the study, the role of a constructivist bricoleur was adopted. As this positioning is central to the discovery of knowledge that flows from this thesis, a review of the practice of bricolage is required.

Bricolage

Denzin and Lincoln (1994) argue “multiple methodologies of qualitative research may be viewed as a bricolage” (p. 3). Essentially, this embodies a complex, reflexive, collage-like creation of researcher understandings regarding a researched phenomenon (McLeod, 2003). This view contends qualitative researchers are a ‘jack of all trades’ when they take on the role of bricoleur. Turning to the anthropological ideas of Levi-Strauss (1966), Denzin and Lincoln propose bricolage embodies “a combination of multiple methods, empirical materials, perspectives and observers in a single study” that add “rigour, breadth and depth” (p. 2). Essentially, they view the researcher as a metaphorical quiltmaker who “pieces together a set of representations fitted to the complexities of a complex, specific situation” (p. 4). Moreover, Denzin and Lincoln assert bricolage takes on new forms as tools, methods, and techniques of representation become available. Patton (2002) agrees the practice of bricolage posits research constitutes a pieced-together, close-knit set of practices that provide concrete solutions to a specific problem. To achieve

this, the bricoleur uses tools of their trade to select appropriate research practices for a specific study. Questions posed and their contextual positioning determines tools selected. Furthermore the researcher-bricoleur performs large numbers of diverse tasks adeptly and skillfully. These range from interviewing and observing to intensive self-reflection and introspection (Hammersley, 2004).

In keeping with this ethos, this study incorporates the elements of bricolage in a wide range of methods and procedures that reflect its rich design quilt. These multi-dimensional strategies shape data construction. In addition, the overt reflexive components, evidenced in the prologue and diary entries, are testament to the importance of critical reflexivity as a feature of bricolage. Accordingly, the next task of this chapter details the bricolage enacted in the methods and procedures implemented to give practical effect to the study. As strategies used to develop the research population and generation of overarching themes were conducted in two phases, the commentary that follows reflects this organizational structure.

Research Populations

The study consisted of two separate research populations that were developed to facilitate a thick and rich response to the thesis question (Geertz, 1973). This was based on the praxis of qualitative inquirers who select research participants likely to convey expansive understandings of a specific phenomenon (Polkinghorne, 2005). Coined purposive sampling (Patton, 2002), this approach encourages participants to reflect on their experience of a phenomenon and convey this to the researcher in as much detail as possible. Indeed, Patton (1990) recommends researchers choose “information-rich cases for study in depth” (p. 169). Although this type of research population generally consists of small numbers of participants, their contribution is enhanced by the depth and diversity of their insights. Moreover, as researchers compare and contrast participant narratives, they are more likely to notice common themes and points of difference. In this sense, multiple participants represent a form of triangulation that locates the core meaning of participant experience by approaching it through different accounts. Thus, this method enables researchers to move beyond

a single view of an experience and deepen understanding of the investigated phenomenon (Crabtree & Miller, 1999). In addition, snowball sampling was implemented to enlarge the research population. This refers to a practice in which participants recruit future members from amongst their community of interest. Thus the size of this population grows like a rolling snowball. As the sample builds, more and more data is elicited. Eventually this material is used in the analytical process to provide meaningful and trustworthy findings (Marshall, 1996).

Two Purposive Populations

Specifically the study constructed two different purposive research populations to elicit two different types of data. This decision was informed by a number of influences that included the aim of the thesis question, the epistemological stance of the researcher, and methods of data construction and analysis. In view of the duality of the thesis question, the study was divided into two separate phases that reflect these differences. Accordingly, the following discussion examines each of these purposive samples as separate entities.

Function of Phase One Population

The rationale that informed selection of the research population of the first phase of the study was based on locating individuals who could identify West Australian expert psychotherapeutic practitioners. However this posed practical problems for the researcher and her supervisory team. Difficult questions arose as to who could nominate expert psychotherapists and how might this be achieved in a responsible and equitable manner. Given the limited demographics of the West Australian psychotherapeutic community, these matters posed serious concerns. Questions such as could development of the research populations be realized in such a small community arose? Moreover could the peer nomination process be undertaken in a confidential way that ensured the privacy of nominees and nominators? After lengthy discussion, it was decided that a blind confidential nomination procedure constructed by West Australian psychotherapy trainers was an appropriate way to meet this condition. This

realization emerged from the belief that these individuals were likely to be aware of the nature of therapeutic expertise as well as specific West Australian practitioners who met this criteria. Thus the research population in the first phase of the study were identified as West Australian trainers and educators in psychotherapy.

Membership of Phase One

Members of the phase one research population sample consisted of two types of trainers: i) Psychologists registered by the Psychologists Board of Western Australia who taught psychotherapy at local tertiary and private institutions and/or ii) Psychotherapists recognized by the Psychotherapists and Counsellors Association of Western Australia (PACAWA) and/or the Psychotherapy and Counselling Federation of Australia (PACFA) who taught psychotherapy in local tertiary and private institutions. The appointment of these participants was derived from two separate sources; internet websites in the public domain and snowball referrals.

Firstly, internet websites of West Australian universities and private institutions that offered training in psychology and psychotherapy were investigated. These inquiries ascertained the identity of individuals who met this criterion. When three trainers who fulfilled this requirement were identified they were invited to participate in an interview conducted by the researcher. When each of these interviews was completed, the researcher introduced the second method used to develop the size of the research population - snowball sampling. Accordingly each interviewee was asked to identify West Australians psychotherapy educators and trainers. Consequently these individuals were invited to participate in the study. This two-pronged approach to develop this research population was repeated on numerous occasions until the research population reached saturation. This occurred when thirty two West Australian psychotherapy trainers had been interviewed.

Development of Phase One

To develop the research sample a number of procedural steps were taken. These are listed for ease of understanding:

- i. After establishing the identity of three West Australian psychotherapeutic trainers within the public domain, the researcher sent a letter of invitation requesting their participation in the study. A copy of this correspondence is attached to the appendices of this document and marked 'Appendix A';
- ii. Approximately ten days later the researcher telephoned trainers who received letters of invitation. If they agreed to participate, they received letters of confirmation that advised the date, time and place of interview between themselves and the researcher. This correspondence also contained information about the topics to be discussed, procedural aspects and an informed consent form to be completed prior to commencement of the research process. A copy of this documentation is attached and marked 'Appendix B';
- iii. On completion of each interview participants were asked to recommend other West Australian trainers who met the criteria of the first phase. The researcher invited these nominees to take part in the study by implementing the procedures previously discussed.
- iv. As this process was replicated throughout the development of this phase, a snowball sample of psychotherapeutic trainers developed. However, when participants were unable to identify new names of psychotherapeutic trainers, the researcher instigated further searches of internet sites to identify these individuals;

Sample development ceased when the snowball reached saturation and the researcher had contacted most West Australian trainers listed in the public domain.

Function of Phase Two Population

The thesis question sought the understandings of expert West Australian psychotherapists regarding the determinants of effective praxis. As this source of knowledge is an exemplar of judgment-based practice wisdom it fits within Dewey's (1933) notions of reflective practice, Polkinghorne's (2004) practice-based background effects, and Schön's (1987) notions of reflection-on-action. Accordingly, this rationale directed

the development and membership of the research population in the second phase of the study.

Membership of Phase Two

As psychotherapy trainers were considered an appropriate cohort to identify West Australian expert psychotherapists, a specific procedure was designed to achieve this objective. At the end of each interview in the first phase, trainers were asked to nominate three individuals whom they perceived to be an expert West Australian psychotherapeutic practitioner. This request was facilitated through the use of a blind nomination procedure to ensure the privacy and confidentiality of all parties. Accordingly, nine West Australian psychotherapists were identified as expert practitioners. The procedures that facilitated this development are detailed in the next stage of this discussion.

Development of Phase Two

As the purposive sample in the second phase of the study consisted of expert psychotherapeutic practitioners nominated by the participants in the first phase of the study, the researcher implemented the following procedures to construct the purposive sample of the second phase:

- i. On completion of each first phase interview, respondents were presented with a blank nomination form. A copy of this is attached to this thesis and marked 'Appendix C';
- ii. Participants were asked to nominate three West Australian psychotherapists they considered expert practitioners and insert their names on the form in preferential order;
- iii. Before commencement of the nomination process a number of measures that ensured its confidentiality were implemented that included the following procedures:
 - a. Participants were asked to fill in the nomination form making sure they omitted all identifying marks that could reveal their role in the nomination process;

- b. To support the integrity of the nomination process the researcher left the room whilst participants completed their nominations in private;
 - c. Participants were asked not to disclose the names of nominees to any individual associated with the study;
 - d. Each participant was handed a stamped self-addressed envelope directed to the attention of a supervisor of the research project at Curtin University of Technology. Participants were asked to place nominations into this envelope and post it within the next two days. Moreover they were advised this would be held in a locked box until the end of the first phase of the study;
- iv. At the conclusion of the first phase, the researcher and a supervisor of the study opened the envelopes and analyzed nomination forms. They determined nominations generated the names of ninety-one West Australian psychotherapists. However as most of these were replicated, the researcher calculated that forty West Australian psychotherapeutic practitioners were nominated. This cohort included twenty three women and seventeen men;
- v. The researcher collated the names of all forty practitioners on a master list detailing the number of times each practitioner was nominated;
- vi. Practitioners who were nominated four or more times on the master list were deemed members of the research population in the second phase of the study. In total, nine expert practitioners were identified by the study. This cohort included three women and six men. Accordingly the researcher contacted each of these individuals by telephone to advise they had been nominated as an expert. As all nominees agreed to participate in the second phase of the research a letter of confirmation that included an informed consent form was mailed to each participant. A copy of this correspondence is included in this thesis and marked Appendix 'D'.

Construction of Research Material

The qualitative interviews enacted in both phases of this study involved the meeting of two people and the formation of a relationship. Essentially, researcher and participant co-constructed textual material that was multi-voiced and narratively structured. As Dillard (1982) suggests this type of interview is an active text that embodies a fabrication, a construction and a fiction that represents an “ordering or rearrangement of selected materials from the actual world” (p. 148). Thus every interview text reconstructs that world according to its own narrative logic.

With reference to this study, two different types of qualitative interview were used to elicit research material that informed the findings of the study. In the first phase a semi-structured, conversational interview was implemented. In the second phase, an open, unstructured conversational format was applied. Accordingly details of these questions and prompts are attached to this thesis document and marked Appendix ‘E’. The next task of this discussion describes each of these procedures used to explore participant understandings.

Phase One: Semi-Structured Interviews

Semi-structured interviews were conducted that centred on a single objective: to ascertain the attributes of expert psychotherapeutic practice as viewed by trainers in the field. Accordingly, participant and researcher contributed their reflections on this issue in an open semi-structured framework. According to Hitchcock and Hughes (1989), this “allows depth to be achieved by providing the opportunity on the part of the interviewer to probe and expand the interviewee's responses” (p. 83). Consequently, balance between interviewer and the interviewee developed that provides room for negotiation, discussion, and expansion of the interviewee's responses. However a number of assumptions informed this selection. Firstly, informants were presumed to have developed understandings about the attributes of expert praxis. Secondly, this terrain was mined through open ended questioning. Thirdly, although the subjective knowledge of respondents was revealed this was mediated by researcher interpretations

that mediated the study's findings. Fourthly, as the study evolved, the researcher gradually gained insight into participant ideas. This was informed by collaborative co-constructions between participants and researcher that emerged from hermeneutic conversations. These conversations were committed to the tenet that "paradoxically, your experience is *made* mine; I experience my experience of you" (Kapferer 1986, p. 189). As Gergen and Gergen (1991) point out although the researcher's voice was distinct from the participant's voice, the researcher's voice was grounded in participant experiences that reflected common understandings.

Application of Procedures

In terms of the procedures designed to affect first phase interviews, a semi-structured schedule of questions and interview prompts was developed. Audio-recorded interviews of fifty minutes were conducted with each of the thirty two participants within in the following manner:

- i. Initially general questions that addressed professional training and experience were asked to establish a confident and relaxed investigative environment;
- ii. As discussion progressed, questions concerning the attributes of expert praxis were posed. As this issue constituted the major focus of interviews, specific, context-driven questions increasingly took over the conversational thrust;
- iii. As conversations developed and expanded they became spontaneous encounters. Thus researcher inquiries prepared in advance were gradually abandoned. This brought greater flexibility to both researcher and participants in probing for details likely to illuminate the features of expert practice. Nevertheless, researcher and participant reflections identifying key themes in the early stage of interviews provided a sense of order to these encounters (David & Sutton, 2004).

Phase Two: Unstructured Conversational Interviews.

Multiple unstructured conversational interviews were conducted with participants in the second phase of the study. This in-depth approach realized the major aim of the study – an understanding of what makes psychotherapy work from the perspective of West Australian expert psychotherapeutic practitioners. Essentially, this interviewing stance implies that researchers generate questions in response to participant narratives. Specifically, they rely on the quality of social interaction between themselves and participants to elicit relevant responses. Indeed Punch (1998) argues that conversational interviews empower researchers to understand complex human behaviour without imposing limitations that compromise the field of inquiry. Patton (1990) refers to this as the spontaneous generation of questions that are part of the natural interaction between participant and researcher. Indeed, Minichiello (1995) defines conversational interviews as discussions that omit pre-determined question and answer categories.

With these diverse explanations in mind it is apparent that each conversational interview spawns research material characterised by different structures and patterns. Yet researchers who use this method share a common goal to bring forth unanticipated themes that lead to better understandings of participant perceptions about social realities. Nevertheless, as Zweig (1948) contends, conversational interviews require thorough researcher preparation that aims to achieve detailed insights into the lived experience of informants. Thus researchers generally scope the ambit of issues they wish to explore prior to commencement of the interviewing process (Fife, 2005). Furthermore, although researchers maintain limited control of these conversations, they focus on participant experiences relevant to their concerns (Burgess, 1984). Indeed, Minichiello, Aroni, Timewell, and Alexander (1990) posit this method is “always a controlled conversation, which is geared to the interviewer’s research interests” (p. 93). In keeping with this ethos Denzin (1986) contends implementation of conversational interviews depends upon the epistemology and objectives of a specific research project. However

Robertson and Boyle (1984) submit that researchers who implement conversational interviews generally hold a constructivist view of reality informed by the interpretive research paradigm. This approach contends researchers make sense of respondent worldviews by approaching them from their subjective perspective. Thus, as Denzin points out, the purpose of this form of inquiry looks to theory development rather than empirical theory testing.

Although the majority of conversational interviews track respondent narration, they also generate a series of spur-of-the-moment questions based on researcher reflection of this material. Nevertheless, as McCann and Clark (2005) point out, conversational interviewing is frequently guided by an agenda that constitutes a broad guide to topic issues that may arise. Generally this open-ended, flexible device does not structure topics of interest but acts as a reminder of relevant issues consistently revised by respondent reflections. This facilitates a level of uniformity that may be applied across all interview sessions that results in a balance of flexibility and consistency (Briggs, 2000; Burgess, 1984).

Application of Procedures

Within the context of this stage of the study, three separate, sixty minute conversational interviews were conducted with each of the nine informants identified by the blind nomination procedure as experts. This procedure meant that approximately twenty seven hours of research material was generated. Each set of interviews relied upon the interpersonal connection between participant and researcher that enabled reflection upon understandings regarding what makes psychotherapy work. In developing knowledge of this social reality, an iterative generative process of eliciting reflections in response to issues was implemented. As each participant engaged in a series of conversations with the researcher, this recursive reflective praxis enriched the quality of joint exploration (Dokecki, 1992). This reiterative process ensured the emergence of additional issues throughout the development of the study. These evolved gradually, stemming from participant answers to previous questions,

narratives elicited in prior interviews, as well as stories told by other informants.

Specific benefits attained from these sequenced, multiple meetings included enhanced rapport between researcher and participants (Minichiello et al, 1990); heightened awareness of personal transformations that occurred during these conversations within both researcher and participants (Burgess-Limerick & Burgess-Limerick, 1998) ; increased opportunities to check participant understandings and clarify researcher interpretations (Stewart, 1990), and exploration of multiple and contradictory truths encountered by participants and the researcher (Wiersma, 1988).

A significant feature of this two-way reflective approach is the acknowledgment this method challenges the conventional construction of the research interview. Traditionally qualitative research regards interviews as the process of eliciting textual material from the researched by the researcher. Instead, this study viewed both parties as partners, collaborators and co-constructors of knowledge gleaned through mutual exchange of ideas (Burgess-Limerick & Burgess-Limerick, 1998). Essentially, the researcher was viewed as an active and reflexive listener who reconstructed, embellished, and conveyed participant narratives (Bruner, 1986; Gillett, 1995; Marshall, 1986). As Geertz (1988) points out, researcher interpretations are shaped by their social and historical positioning through "reflexivity, dialogue, heteroglossia, linguistic play, rhetorical self-consciousness, performative translation, verbatim recording, and first person narrative" (p. 131). Additionally, Burgess-Limerick & Burgess-Limerick postulate researcher positioning adds depth to participant stories and assists readers to evaluate the trustworthiness of researcher interpretations. Indeed, the biographical details, philosophical stance, and values of the researcher are important aspects brought to this study. Henwood and Pidgeon (1995) recommend these features be reported to facilitate the credibility of the study.

As the focus of this activity centred on the verbal and non-verbal connection between participants and researcher, the researcher concentrated on the quality of meeting that arose between the parties. This

required a highly sensitive response to situational changes within participants and the research environment. Furthermore psychotherapeutic training of the researcher proved helpful in developing rapport and empathy. Thus this affective relating, established over multiple interviews, encouraged high levels of receptivity, reflection and discussion by participants. Researcher skills that encouraged this outcome included the facility to listen carefully for nuanced changes in the flow of conversation; the ability to direct conversations; the capacity to reflect on respondent narratives, and generation of insights that formulate questions quickly and smoothly (Patton, 1990, p. 29). The researcher was also required to display sophisticated probing skills appropriate to the level of discourse. Indeed, Spradley (1979) recommends that researchers be adept at three related probing activities. Firstly the posing of descriptive questions that enable participants to detail their activities. Secondly, structural questions that establish how participants organize knowledge are helpful. Finally, when contrast questions are posed this enables participants to compare different situations in the search for meaning. Moreover these probes encourage informants to reflect more deeply to elicit enhanced understandings. Although it is not possible to capture the dynamic quality of these diverse modes of questioning as they are informed by moment-to-moment contextual changes, Appendix 'D' reveals the probing style adopted in this phase of the study.

As conversational interviews are joint constructions of researcher and respondent exploration, some discussion of the interpersonal dynamics involved in this exchange are presented. In particular, this explanation draws on Ogden's (1994) analytic third from psychoanalytic psychotherapy. Diamond (2007) contends this concept, also referred to as 'thirdness' embodies a psychological space that exists between client and therapist and leads to new insights "where things actually happen" (p. 142). In effect, the analytic third is created when psychotherapist and client make genuine contact extending the duality of understandings to a new expanded level. Likewise it may be argued that participant and researcher bring their understandings to the research context and manifest a third level of

enhanced knowledge as a result of this meeting. Nevertheless there are inherent dangers on this process of meeting. Patton (1990) cautions researchers to “guard against asking questions that impose interpretations on the situation” (p. 282). Denzin (1983) concludes that although “sympathetic identification” of respondent points of view is necessary, researchers should avoid giving advice and passing judgments.

Analysis of Research Material

As this study adopts a constructivist stance that fosters researcher and participant co-construction of research material, the interpretive procedures implemented were pivotal to the analysis of research material. Consequently, an embodied grounded theory emerged that incorporated inductive, deductive and abductive protocols. Accordingly, this theorizing supported reiterative reflection and comparison that led to the findings of the study. Before describing the grounded theory that developed in this context, a brief overview of this research method is presented.

Grounded Theory

Grounded theory derives its theoretical underpinnings from symbolic interactionism and American pragmatism (Plummer & Young, 2009). Blumer’s (1969) symbolic interactionism posits people act towards phenomena based on the meanings they attribute to them. Alternatively, pragmatism spearheaded by James (1904), Dewey (1933), and Peirce (1955) holds that both meaning and truth are functions of identifiable outcomes. In view of these influences, grounded theory emerges as a problem-solving endeavour concerned with understanding human action (Strauss & Corbin, 1990). Although there are multiple forms of this notion, these generally mirror the philosophical positioning of researchers (Hallberg, 2006). Consequently, grounded theories reflect a variety of paradigms that include positivistic, post positivistic, and constructivist concerns. Accordingly the precepts of grounded theory differ as they reflect these differing paradigms. Accordingly they are coined the classic model, the reformulated model, and the constructivist model. Despite this diversity, commentators such as McLeod (2001) attempt to generalize the major components of

grounded theory. Specifically, he postulates three distinct attributes characterize most emergent grounded theory. Firstly, McLeod (2001) contends grounded theory embodies an analytical tool that centers on discovery of new ways to make sense of the social world. Secondly, data collection and analysis that typify grounded theory emphasizes theory generation constitutes a formal framework for understanding a phenomenon. Thirdly, emergent theory is always 'grounded' in textual material that is analyzed by researchers sensitive to potential multiple meanings. Specifically this process is informed by researcher immersion in elicited data. As a detailed knowledge of the diversity of grounded theory is beyond the scope of this thesis, this discussion focuses on the formulation most suited to the epistemological stance of this study. As this espouses a constructivist thrust, the grounded theory introduced by Charmaz (2003, 2004, 2006, 2008) is adopted.

Constructivist Grounded Theory

Although researchers espouse diverse interpretations of constructivist grounded theory (Nelson & Poulin, 1997; Norton, 1999; Stratton, 1997), this study bases its design on the Charmaz (2000) model that asserts "data do not provide a window on reality. Rather, the 'discovered' reality arises from the interactive process and its temporal, cultural, and structural contexts" (p. 524). Essentially, this approach emphasizes the subjective interrelationship between researcher and participant and their co-construction of knowledge that emerges from the interpretation of research data (Hayes & Oppenheim, 1997). In particular, constructivist approaches view investigators as part of the research endeavour rather than objective observers. Thus their values are an inevitable part of the research process and its outcomes (Appleton, 1997; Guba & Lincoln, 1989; Stratton, 1997). As constructivists assume their subjectivities enter data collection and analyses, Charmaz (2009) asserts researchers are required to explicate their positions, situations, and interactions and how these influences inform data construction. Nonetheless, although Charmaz (2008) challenges the classic model's view of researcher as "distant expert" (Mills, Bonner, & Francis 2006, p. 7), this constructivist stance affirms researchers are required to

keep the words of participants intact throughout the data construction process (Jones & Hill, 2003). Indeed, Charmaz (2000) points to the delicate balancing act of researchers that enables participant accounts to retain a degree of visibility so that readers have the capacity to make connections between the findings of the study and the data from which they emerge (Fossey, Harvey, McDermott & Davidson, 2002). Charmaz argues this level of transparency demonstrates the value researchers place on participants as contributors to the construction of the final grounded theory model. Nevertheless, it also meets the researcher's ethical obligation to "describe the experiences of others in the most faithful way possible" (Munhall, 2001, p. 540).

Charmaz (2006) also posits that constructivists view data as situated in researcher/participant action and interaction. Accordingly, constructivist grounded theory constitutes interpretative understandings that demonstrate credibility, originality, resonance and usefulness. Moreover, Charmaz (2009) contends that when constructivists engage with data they focus on tacit, liminal meanings as well as explicit statements and actions by participants. Charmaz (2003) also posits that although constructivist grounded theory adopts inductive, comparative, open-ended approaches, it also negates the reductionist coding of Strauss and Corbin's (1990) post-positivistic model. However the constructivist approach also incorporates the abductive logic of this reformulated model as an accompaniment to induction processes. This stance stresses that constructivist theorists borrow Peirce's (1955) logic of abduction to refine development of data categories. Essentially, Charmaz posits abductive theorizing trails inductive inquiry. Thus this inclusion takes investigative efforts further than classic and reformulated grounded theory. Consequently, when grounded theorists discern an unexpected finding, implementing abductive logic, they consider all theoretical ideas that account for this event. Accordingly, researchers return to the field to gather more data that tests this idea before adopting a plausible theoretical explanation for the finding.

In summary, constructivist grounded theory highlights the complex ambiguities that researchers confront in the process of data construction

and analysis. In particular, these tensions manifest in balancing meaning-making processes that interpret participant stories with the need to maintain a sense of their presence in the final text. Nevertheless despite these difficulties, this method empowers researchers to penetrate deeply into a phenomenon without isolating it from its social location. This intimate approach enables researchers to examine the core of a phenomenon and define its essential properties. Thus new insights occur that challenge old assumptions despite revealing inherent ambiguities.

Application of Constructivist Grounded Theory.

As indicated this research adopted the tenets of constructivist grounded theory in view of the ontological and epistemological assumptions of the study. Accordingly, researcher and participant subjectivity are foundational notions implicit in the co-construction of data. This includes the assumption that multiple realities exist and these inform the mutual construction of data through therapist and participant interaction. In addition, the representation of data is problematic, situational, and partial and assumes the views of researchers. Reflexivity and constant comparisons are hallmarks of the inductive, deductive, and abductive processes. Accordingly, these tenets are described in the coding and construction of data detailed below.

In keeping with grounded theory, the collection and analysis of research material was synchronized. This meant that research interviews were analyzed immediately after they occurred. Hence an emergent framework manifested that sensitized the researcher to issues to be explored in the next interview. Development of research material was concluded when a system of categories constructed by the researcher was saturated. In effect, when the researcher ceased to gain new insights this concluded all inquiry. Specifically, construction of research material in the first phase responded to the secondary aim of the thesis question: the identification of attributes of expert psychotherapeutic praxis. Accordingly, the second phase responded to the primary purpose of the research question: determination of the informants of effective psychotherapeutic

praxis. Pursuant to this process categories of research material were eventually established in the following manner:

- In the first phase of the study multiple open codes and categories of research material emerged. Each code identified 'meaning-units' within the text such as the personal attributions of expert practitioners and their informants. For instance, relational sensitivity was identified and linked to early childhood experiences. These open codes eventually generated categories that determined experts were receptive individuals whose early history informed their ability to be emotional available to client needs;
- In the second phase of the study open codes and categories that emerged included therapist processes that led to enhanced therapeutic outcomes. Although the researcher categorized research text that determined the informants of effective therapy, these categories were framed in terms of actions and processes. Specifically, each entry stated the title of the category and the meaning unit to which it referred. For instance therapist acumen, the capacity to make connections and ability to challenge clients were actions identified as processes that encouraged effective therapist interventions. Eventually these constructs were combined into a category named 'emotional intelligence' that informed new theory formulations about what makes therapy work;
- Consequently in both phases of the research, the researcher examined categories in their entirety to identify higher order categories. The connection between categories was explored through a process of classification known as 'axial coding'. This involved the identification of conditions under which categories occurred and their consequences.
- In the first phase of the study, the researcher identified the category of the capacity to tolerate ambiguity as an attribute of expert practice. Then this was linked to other categories such as acumen, problem solving, and curiosity. The axial coding that linked these

categories was identified as cognitive capacity. Eventually cognitive development was identified as an emergent feature of expert psychotherapeutic practice;

- Throughout both phases of the study, research material elicitation and analysis implemented a method of constant comparison so that all categories identified by the researcher were compared and contrasted within and across the study. To attain this effect the researcher engaged in reflexive, iterative generative processes that led to the refinement of the system as a whole;
- Replication ensured that interpretation of coded and categorized text material was undertaken in a comprehensive, systematic manner. Essentially ideas stemmed from three distinct domains: the common sense constructions of the researcher; technical terms drawn from professional literature, and respondent language and researcher interpretation of these ideas. For example, in the first phase of the study expert psychotherapists were coded as receptive, non-defensive, and resilient individuals. Accordingly, these meaning-units combined to construct the category of emotional expertise. This category was then compared with other categories as well as the study as a whole. Accordingly, the study conceptualized new theoretical understandings about the characteristics of therapeutic mastery.

Throughout all stages of research material collection and analysis the researcher kept memos and flow charts of elicited textual material. This facilitated development of theoretical ideas and a conceptual framework that supported the storage of emergent notions to be used when appropriate without interfering with the painstaking attempts by the researcher to keep as close as possible to the grounded material. For instance, the researcher mapped a multi-dimensional six phased process model to demonstrate interactional development between therapist and client that determines effective psychotherapy. This is discussed in the epilogue of this thesis.

When working with the material, the researcher mapped the overall set of meanings being discovered as well as one or more of the key themes that captured the core meaning of the phenomenon being studied. For instance one of the key themes of the study postulated that expertise in psychotherapeutic practice consisted of high levels of cognitive development. Lower level codes that embodied cognitive expertise included cognitive capacity, the ability to tolerate ambiguity, and a love of learning. However the study considered other aspects of expert praxis that emerged from the study such as therapist relational maturity. Whilst the majority of low level codes and categories employed descriptive terms, main categories reflected the emergent conceptualisation of the data. Ultimately the main categories possessed sufficient theoretical resonance to link results of the study to findings and theories from other studies.

Trustworthiness of the Study

As researchers are required to subject their inquiries to critical scrutiny to evaluate its robustness, appropriate criteria that assess legitimacy are encouraged. Ideally, practices should reflect ontological and epistemological assumptions that inform the study. Thus, as this inquiry captures the phenomenological understandings of two research population derived from phronetic practices, techne expressions of reliability and validity do not apply. However, although the former are less common than empirical, positivistic efforts, established researchers such as Denzin and Lincoln (1994) suggest a wealth of criteria is available for this purpose. Specifically, they offer an array of techniques that evidence appropriate methodological rigour they do not conform to traditional rationalist practices (Guba & Lincoln, 1994).

In providing guidance on this endeavour, Polkinghorne (1989) argues evaluating the trustworthiness of any research investigation involves judgment as to whether a study “inspires confidence because the argument in support of it has been persuasive.” (p. 57). Moreover, to achieve this Polkinghorne states “the reader must be able to follow the processes that have led to the conclusions and to accept them as valid” (p.57). In view of this clear and broad directive, a plethora of methods that seek to assure

research trustworthiness currently exist within the landscape of qualitative research. Although many of these standards of address credibility, transferability, dependability and confirmability, Morrow (2005) argues these protocols are questionable as they constitute postpositivistic practices that smack of rationalist, objectivist notions of validity and generalizability.

An alternative approach, increasingly adopted by constructivist and critical paradigms, privileges diverse strategies that promote authentic research in terms of Polkinghorne's (1989) guidelines (Chambers, Wedel, & Rodwell, 1992; Lincoln, 1990). For instance, Patton (2002) favours methods of credibility that embrace subjectivity whilst Mertens and Ginsberg (2008) argue dimensions of self and other are relevant in constructivist contexts.

In an effort to integrate these diverse criteria into a single synthesis, Williams and Morrow (2009) attempt a consensus that affirms trustworthiness in all qualitative contexts. They suggest three major categories ensure research fidelity that incorporate a focus on i) the integrity of research material gleaned in any study; ii) a balance of reflexivity and subjectivity as essential features of the research process and iii) clear communication of findings. As these researchers are leading qualitative researchers in the domain of counselling psychology, their views are considered pertinent to the parameters of this study. Accordingly, the penultimate goal of this chapter examines the meaning and relevance of these notions and their application this study.

Integrity of Textual Material

Although integrity of textual material refers to the adequacy of a study (Morrow, 2005), it is difficult to know when this standard is realized. Williams and Morrow (2009) consider clear articulation of a study's methods that allows for replication is sufficient to assure its integrity. However they also recommend researchers present additional evidence that conveys the quality and quantity of gleaned research material. In terms of quality, Williams and Morrow (2009) encourage researchers to recognize that diverse perspectives within a study are helpful such as member checks and researcher panel reflexivity with regard to emergent themes. In terms of

quantity, Johnson, Hayes, and Wade (2007) posit categories of research material that are fully fleshed out and saturated grasp the richness and complexity of constructs under investigation.

Balance between Subjectivity and Reflexivity

Williams and Morrow (2009) also claim research is trustworthy when it reflects a balance between participant statements and researcher interpretations of these statements. Essentially, this balance turns on two related concepts: subjectivity and reflexivity. With regard to subjectivity, Williams and Morrow claim all research is subjective because bias “enters the picture as soon as a research question is asked in a particular way, in a particular setting, by a particular person, for a particular reason’ (p. 79). Moreover, although Johnson et al., (2007) proclaim that qualitative researchers do well to recognize the benefits of subjectivity, they also recommend researchers attempt to manage this bias through reflexivity. In clarifying the meaning of reflexivity in this context Rennie (2004b) defines it as awareness of self. This suggests researchers remain self-reflective and able to identify what derives from participant input and what emanates from their own contribution. To achieve this Rennie alludes to a variety of different methods such as bracketing biases as well as self-reflective journaling. Both strategies enable researchers to remain attuned to their own perspectives, thus ensuring their capacity to differentiate between participant and researcher narratives. Lincoln and Guba (1985) also recommend member checking to ensure researcher interpretations honour participant meanings together with respondent feedback at multiple points in the research process. Indeed both strategies support both parties to enhance their collaborative relationship revealing whether a balance between participant voice and researcher interpretation are achieved.

Clear Communication

Williams and Morrow (2009) also assert trustworthiness turns on the clear articulation of findings. Specifically, they argue psychotherapy research is trustworthy if justified by professional objectives such as improvements in process or outcome within the domain; exposure of

limitations in current therapeutic or methodological approaches; fostering of dialogue on topics important to psychotherapy and new courses of action based on elicited research material. These theorists also stress clear communication implies researcher interpretations are trustworthy if they easily understood by the reader, supported by participant quotes. Furthermore, they posit researchers are required to demonstrate evidence they have answered the research questions articulated at the commencement of the study and throughout its development. Ponterotto and Grieger (2007) assert that “thick description” is the “linchpin of qualitative writing” (p. 415), claiming trustworthiness is established through researcher “understanding and absorbing the context of the situation or behaviour” (pp. 415-416). These imperatives emphasize the interpretive task of researchers that illustrate participant meanings in the contexts of their lives. In addition to acknowledging the purposes of the research study and its related context, Williams and Morrow, (2009) also stress psychotherapy researchers are also required to discuss current theory and practice and tie their findings to existing literature.

Application of Trustworthiness Criteria

As this study reflects a relativist, constructivist stance it incorporates many of the trustworthiness criteria espoused by Williams and Morrow, (2009). Essentially the following procedures were implemented to ensure the trustworthiness of its findings:

- i. A reflexive journal that traced the collection and analysis of data was maintained throughout both phases of the research. This document reveals the researcher’s subjective responses throughout the study and also includes the input of a specialized reflexivity panel appointed to assist the researcher in thinking about the study. However as this record contains personal musings of the researcher as well as the reflexivity panel and also reveals aspects of participant identity, a copy of this reflexive journal is omitted in this thesis;
- ii. Throughout both phases of the research, transcripts of interview were triangulated by the auditing of a senior member of the

reflexivity panel. Consequently this praxis provided valuable feedback that enabled deeper levels of reflection-in-action by the researcher (Schön, 1987). This supported the refinement of the grounded theory that gradually emerged from the research process.

- iii. The reflexive journal was also instrumental in the determination of overarching themes. Specifically the researcher mapped category and sub-theme development that tracked the evolution of researcher ideas. A copy of these document is included in this thesis and marked Appendix "F";
- iv. Aspects of the reflexive prologue and epilogue disclose the bias and subjectivities of the researcher with regard to the thesis question;
- v. In terms of member checks and audit trails recommended by Lincoln and Guba (1985) the researcher adopted the following strategies:
 - a) On completion of the second phase of the study, typed transcripts of all research material were forwarded to each participant who took part in this stage of the research for the purpose of member checks. Accordingly, these informants were asked to comment on the content and accuracy of the interview and invited to add further relevant material summary of the themes that emerged from the research material generated by each participant was sent to them for individual private review and comment. As inclusion of all nine summaries would require expansive documentation, only one copy of these audit summaries is included in this thesis. This is marked Appendix "G";
 - b) From time to time during the second phase, the concepts, codes, and categories were subjected to review by members of the researcher's supervisory team. This body assisted the researcher in recognizing emergent patterns in elicited research material and the identification of core categories and themes.

In terms of the integrity of data espoused by Williams and Morrow (2009), the study included diverse methodologies, methods, and procedures to enhance the trustworthiness of findings. As the research material

emerged, the researcher made every effort to maintain the unique subjectivity of participants. This strategy ensured readers had the opportunity to experience the views of participants in terms of the language they utilized. In terms of the quality of the research material, the researcher triangulated member checks and audit checks throughout both phases of the study to provide evidence of its accuracy and depth. Specifically, this was forwarded to an associate member of the study to check whether the study had reached saturation.

In terms of clear communication of the study and its social validity advocated by Williams and Morrow (2009) trustworthiness was demonstrated by highlighting how practice wisdom may be used to identify new knowledge. Specifically, this practice-based knowledge is unavailable to positivistic, objectified testing that typifies the precepts of *techne* that dominate research with the psychotherapeutic domain. Moreover this approach ignores the contextual circumstances of human beings situated in a real world environment informed by everyday procedural understandings. Thus the *phronetic* awareness of master therapists who address the determinants of therapeutic success adds to propositional knowledge in this field.

Additionally, by examining what makes therapy work, the study fostered dialogue on an issue that is considered important to psychotherapeutic practitioners and psychotherapy researchers. The study revealed new courses of therapeutic action likely to improve the effectiveness of psychotherapeutic interventions;

Generalizability of the Study

Research designs typically describe the external validity of a study in terms of generalizability. This notion explores whether insights gained in a particular investigation hold true in other contexts. Even though this issue has limited application in exploratory research, given the specific design of this study and its literature review, generalizability is most pertinent. This determination is informed by contentious scholarly discourse that debates the question of replicability in qualitative research. Although authorities

generally regard generalizability as an expression of reliability and validity assessed through measurement, a close examination of their understandings reveals qualified support for generalizability.

In considering this issue in his role as a qualitative methodologist, Polkinghorne (1991) distinguishes two kinds of generalizability: statistical and aggregate. As statistical generalizability extends findings from a smaller sample group to wider populations, this takes the view that the larger the sample size, the greater the likelihood for generalizability. In contrast, the aggregate model, more consistent with qualitative assumptions, values deep descriptors sufficiently comprehensive to generalize from each member of the research population. Nonetheless, although this conceptualisation of generalizability is accepted by a number of researchers it is hotly disputed by others. Janesick (2000) claims generalizability has no relevance to constructivist, phenomenological research whilst Donmoyer (1990) rejects this absolutist stance. Meanwhile, Goetz and LeCompte (1984) argue qualitative research gains its potential for generalizability through the precepts of comparability and translatability that ensures "other researchers can use the results of the study as a basis for comparison" (p. 228). In a compromising effort, Patton (2002) substitutes 'extrapolation' for generalizability when referring to "modest speculations regarding the likely applicability of qualitative findings to other situations" (p. 584). Nevertheless, Creswell (1998) and Wainwright (1997) emphasize the context-specificity of qualitative research limits its generalization to other situations. Kuzel (1992) asserts that qualitative research aims to reflect diversity within a given population, rather than generalizability or representativeness whilst Cronbach (1975) concludes varied social phenomena are too context-specific to permit generalizability. Alternatively, he suggests qualitative research prioritizes the ability to "appraise a practice or proposition... in context" (p. 124). In a more liberal tack, Stake (1978) argues implementation of 'naturalistic generalizability' empowers qualitative researchers to take the findings of one study and apply them to another study provided that contextual and setting dynamics

of both studies are similar. Significantly, Denzin (1983) also rejects generalizability as improper, stating

The interpretivist rejects generalization as a goal and never aims to draw randomly selected samples of human experience. For the interpretivist every instance of social interaction, if thickly described (Geertz, 1973) represents a slice from the life world that is the proper subject matter of inquiry...Every topic...must be seen as carrying its own logic, sense of order, structure and meaning (p.133 -134).

A more modified response to the question of generalizability is articulated by Guba and Lincoln (1982) who call for exploratory researchers to replace generalizability with their notion of "fittingness" (p. 238). Specifically, they argue this re-conceptualization be adopted provided it enables researchers to analyze the degree to which a situation under review matches other relevant situations. Accordingly, they posit this represents a more realistic and workable way of thinking about the generalizability. In commenting on this recommendation Schofield (2002) makes the point that a logical consequence of this idea turns on whether the supply of information is sufficient enough to reveal the contextual circumstances of the research settings involved. Indeed, Schofield's explication adds insight to the meaning of "transferability", a notion articulated more recently by Lincoln and Guba (1985, p. 124) as an extension of fittingness:

a direct function of the similarity between two contexts....If context A and context B are sufficiently congruent, then working hypotheses from the sending originating context may be applicable in the receiving context.

This thrust is extended further by Strauss and Corbin (1990) who suggest the term "reproducibility" replace transferability to ensure detailed information regarding the research, its context and assumptions are fully conveyed. Henwood and Pidgeon (1992) and Kvale (1995) also make the point that researcher reflexivity and transparency with respect to these matters also enhance generalizability. However it is suggested the original

notion of fit prescribed by Lincoln and Guba links qualitative generalizability most convincingly to the original idea of external validity:

It is not the naturalist's task to provide an index of transferability, but it is his or her responsibility to provide the data base that makes transferability judgments possible on the part of potential appliers (1985, p. 316).

Given this multiplicity of views, perhaps the most constructive stance accepts the notion of generalizability as a bone fide feature of qualitative research, yet redefines its meaning based on contextual factors. With this in mind, Schofield's (2002) position is instructive as she asserts that a consensus exists amongst leading qualitative researchers in regard to this matter. Essentially, this re-casts generalizability as a matter of 'fit' that must be determined between a specific situation studied in detail and another situation that is relevant in terms of its concepts and conclusions. Accordingly, such an approach makes 'thick' descriptions essential within this investigative realm, as without them, it is not possible to assess the issue of fit between the studies.

Nevertheless, despite these enlightened arguments, the fragmentation that characterizes generalizability and its relevance to qualitative inquiry cannot be denied. Therefore, it is suggested this notion requires re-conceptualisation if consistency is to be achieved. As this challenge falls beyond the scope of this thesis, this commentary is limited to an exploration of assertoric knowledge claims (Polkinghorne, 1983) and abductive reasoning (Pearce, 1955).

Assertoric Knowledge and Abductive Reasoning

When considering the legitimacy of specific research findings and their broader populations, Polkinghorne (1983) postulates these outcomes embody diverse phenomena coined assertoric knowledge. Essentially, this notion includes all the products of research that manifest within this study as diverse knowledge claims within the public arena. Therefore, as Bishop (2007) points out, these outcomes encompass rhetoric whose legitimacy is approved or refuted by relevant scholarly discourse. Hence this approach

perceives any research endeavour and its subsequent evaluation as an expression of scientific consensus. This acknowledges that knowledge development is a social process, prefaced on human values and societal dynamics. As this position views all knowledge claims as mutable, fluctuating phenomena it leads to the inevitable assumption that there is no certainty in an uncertain world (Buss, 1975; Sarason, 1982).

This supposition represents a conceptual shift initially flagged by Peirce (1955), the American pragmatist who originated abductive reasoning. This postulates that knowledge claims are speculations drawn from inferences based “on logical combinations of more and less certain information” (Bishop, 2007, p. 12). Consequently, Peirce applies this reasoning to real life circumstances to construct a revolutionary model that challenges positivistic assumptions. This subjectifies the research process, mixing researcher bias with material elicited in any form of exploratory inquiry. Hence, this method of abductive hypothesizing is useful in generating theory gleaned from researcher understandings of phenomena shaped by dynamic social contexts.

Application of Assertoric Knowledge and Abductive Reasoning

In applying assertoric knowledge and abductive reasoning to this study, research legitimacy, credibility, and integrity is strengthened. Specifically, this research implies that the nature of expert psychotherapeutic practice and the informants of effective therapy are now more explicit and transparent. In particular, reliance on abductive reasoning in theory generation and assertoric knowledge claims ensures the trustworthiness of the study is determined by informed debate within the public domain. This approach advances the view that the scholarly community and wider psychotherapeutic interests are the appropriate authorities to assess the merits of this study’s findings. In particular, this stance rests on the belief that its overarching themes stem from the object of investigation. This manifests as knowledge claims that derive from complex intersubjective processes that manifest in meetings between the researcher and the researched. Moreover, this process involves in-depth inquiry, collaborative interpretation, and conceptual generation at overt

and covert levels within the context of the research relationship and its contextual circumstances. Thus assertoric knowledge claims based on the praxis of abductive theorizing are intrinsic aspects of the investigative thrust spearheaded by this study.

Summary of Design Considerations

Commentary in this chapter details the interrelated ontological, epistemological, and methodological assumptions of this research that underpin methods and procedures. Each level in this taxonomy also includes an internal structure that supported this exploratory inquiry. As a relativist, constructivist stance informed the process, a trustworthy grounded theory emerged that privileged practice wisdom. A number of core considerations constituted major features of this research. Firstly, these findings were co-constructed by the subjectivity of both researcher and participants. Moreover, an alternating cycle of conversational interviews and inductive and abductive theorizing characterised this research. This manifested as iterative, recursive movement that led to the development of a series of overarching themes (Behrens & Smith, 1996; Morrow, 2005; Polkinghorne, 2005). This approach provided considerable flexibility in revising the research design, interview questions, and other data construction strategies as the contextual circumstances of the research. In addition, researcher and participant sensitivity to evolving findings comprised a desirable feature of this research (Glaser & Strauss, 1967; Morrow & Smith, 2000). The social location of participants and researcher was also essential in the collaborative co-construction of research material (Morrow, 2005; Suzuki, Prendes-Lintel, Wertlieb, & Stallings, 1999). Additionally, a critically reflexive journal and researcher transparency in the prologue and epilogue of this thesis identified the researcher's position in both investigative phases, providing readers with an understanding of the worldview of the researcher and the lens through which she perceived participants.

As assumptions and biases of the researcher were made apparent in the prologue, this research acquired a level of transparency that supports the rigour of the study (Morrow, 2005). This openness addresses the issue of subjectivity, an implicit feature of constructivist research. Morrow (2005)

also argues that intersubjectivity between researcher and participants, also known as “participatory modes of consciousness” (Heshusius, 1994, p. 15) typifies the relationships in a constructivist study. Consequently, these relationships were central to effective data construction in this study (Miller, 1976; Suzuki, Ahluwalia, Arora, & Mattis, 2007). As participants frequently disclosed information of a sensitive nature, relating between interviewer and interviewee reflected a high level of intimacy. In particular, these reflective moments challenged the researcher to capture and communicate these effects.

Efforts were also made to ensure that sufficient contextual information about the perspective of the researcher and the research process itself was included. This objective aimed to reveal the relevance of the study’s findings in other contexts. This raises the contentious question as to whether findings regarding the attributes of expert praxis and the informants of effectiveness may be generalized to other settings. Although this is a qualitative study, Goetz and LeCompte (1984) argue that qualitative research gains its potential for generalizability by providing substantive comparability and translatability. They argue this requires an appropriate degree of description and definition so “that other researchers can use the results of the study as a basis for comparison” (p. 228). Alternatively, Lincoln and Guba (1985) advocate for the presence of transferability, arguing this notion corresponds with generalizability as it is traditionally understood:

The degree of transferability is a direct function of the similarity between the two contexts, what we shall call ‘fittingness’.

Fittingness is defined as the degree of congruence between sending and receiving contexts (p. 124).

Additionally Creswell (2005) contends, “in qualitative research.....interpretation consists of stating the larger meaning of findings” (p. 48). Patton (2002) substitutes another term for generalizability identified as “extrapolations . . . modest speculations on the likely applicability of findings to other situations which may be made from qualitative research” (p. 584). Indeed theorists such as Mays and Pope

(2000) argue that concepts from quantitative research, including generalizability, may need to be “operationalized differently to take into account the distinctive goals of qualitative research” (p. 50). Alternatively, Schofield (1993) claims general applicability results from the set of methodological qualities evidenced in a study. Essentially this refers to the rigour of the study’s design and methods of data construction (Yin 1989); its attention to triangulation (Patton, 2002), and examination of the literature (Eisenhardt, 2002).

In summary much of the literature is in agreement that qualitative studies may form a basis for understanding situations other than those under investigation. However the strength of this depends on the rigour of a study’s design and methods for gathering and analyzing information-rich data (Yin 1989, 1999), its attention to triangulation (Patton, 2002) and a well-developed theory emerging from the findings (Johnson & Christensen, 2004). This commentary suggests that the depth and thoroughness of this research design meets these requirements.

Chapter Two Schematic Outline (Part A)

Methodological Design of Study

Four Interrelated Design Levels

- Hierarchical ontology, epistemology, methodology & method

1. Ontological Considerations

- Relativist stance assumes reality informed by context so subjective experiences, perceptions & human interactions of researched/researcher shape findings

2. Epistemological Level

- Constructivism & judgment-based practice wisdom privileged
- Constructivism underpins participant/researcher interactions & collaborative interpretations: thus research material co-constructed rather than 'discovered'
- Judgment-based practice wisdom viewed as situationally-driven responses derived from multiple experiential events & interactions
- Practice wisdom = therapy based on context-driven tacit cognitive, emotional & relational acumen: informed by authoritative contributions from Dewey, Schön and Peirce
- Reflexive praxis incorporating Dewey, Schön and Peirce constructs constitutes a parallel process of study
 - Generates co-construction of research material by researcher/participant in Phase I and Phase II
 - Underpins analysis of research material in Phase I and Phase II by researcher

3. Methodological Level

- Qualitative thrust reveals complex, holistic picture of human experience
- Phenomenological considerations examine lived experience from a subjective stance
- Hermeneutic considerations recursive, repetitive interpretations of part & whole of text
- Social constructionist ethos posits participant/ researchers collaborative co-construction
- Substantive theorizing stresses phenomena examined in its social/physical world
 - Study represents research in substantive domain of therapeutic trainers & experts
- Critical reflexivity consists of critical self-exploration of own interpretations
 - Researcher and researched paradox: Researcher adopts this throughout investigative process to enhance inquiry & transparency (parallel process with participants in generation of research material)

Chapter Two Schematic Outline (Part B)

4. Methods and Procedures

Dominance of Bricolage

- Bricolage is complex, reflexive, collage-like creation of researcher understandings that authenticates use of multiple methods & procedures

Multiple Methods

- Purposive research population selected to convey expansive understandings of phenomenon
 - Phase I purposive population of psychotherapeutic trainers most suited to reflect on meaning of expertise & identify Phase II purposive population
 - Phase II purposive population of WA experts nominated by Phase I trainer peer review process
- Semi-structured conversational interviews utilized in Phase I as objective: limited to identifying attributes of expert practice & blind' peer review nomination process in one participant/researcher conversation
 - Method captures researcher/participant co-constructions & interpretations of research material
- Unstructured multiple conversations in Phase II between expert participants & researcher result in:
 - Spontaneous tacit understandings generating theory development like Ogden's analytic third
 - Recursive, iterative joint reflections highlighting affective connection of researcher & participants
- Analysis of research material derived from
 - Reflection-in and on-action & abductive reasoning by participants/researcher in both phases Inductive, deductive & abductive protocols applied
- Constructivist grounded theory emerged retaining explicit statements & actions as well as tacit, liminal meanings of participant & researcher in both phases: subjectivities of all parties' contribution to research process highlighted
- Trustworthiness safeguards affirm qualitative credibility although Polkinghorne argues research confidence depends on persuasive argument
 - Although construction, analysis and interpretation of research material rigorous both research phases implement strategies to satisfy trustworthiness
 - Methods assure integrity, transparency, reflexivity & subjectivity balance, & clear communication.
- Generalizability considerations asserting study's conclusions transferable to other contexts supported by

Phase One Findings

CHAPTER THREE

ATTRIBUTES AND INFORMANTS OF EXPERT PRACTICE

If people knew how hard I had to work to gain my mastery, it would not seem so wonderful at all

(Michelangelo, 1535 in Crawford, 2000 p.38)

The findings of the first phase of this study, revealing the attributes of expert psychotherapeutic practice are detailed in this chapter. Essentially, two overarching themes emerge from the study. The first describes cognitive, emotional, and relational features of psychotherapeutic mastery whilst the second identifies informants of these qualities. Although the research population of thirty West Australian psychotherapy trainers and educators contribute to the development of knowledge in this domain, their findings are similar to understandings ascertained in a range of North American studies. Accordingly the findings of this West Australian research regarding the features and informants of therapeutic mastery are summarized without including research material evidencing these findings. This decision is informed by two major considerations. Firstly, differences between this qualitative study and its North American counterparts are minimal. Secondly, as this part of the study constitutes the first phase research that was mainly intended to construct the research population for the second phase of the study, research material gleaned lacked depth and richness. However, as some differences between this study and the North American situation were identified, these are addressed by the commentary that explores this study's implications and limitations. Moreover, these differences underscore cultural and contextual features that are likely to account for these variations.

Overview of Phase One

Two different research questions to two distinct research populations in two separate phases of exploratory inquiry are featured in this study. In the first phase, thirty-two West Australian psychotherapeutic trainers were asked to identify the features of expert psychotherapeutic praxis. They were also asked to nominate three West Australian psychotherapists they considered to be experts in their field. Essentially, this phase of the study aimed to glean the subjective understandings of West Australian psychotherapists who facilitated training in this domain. As two overarching themes were identified, each of these and their associated sub-themes are presented in this chapter. The first of these establishes that cognitive, emotional, and relational attributes characterize expert psychotherapeutic praxis. The second theme determines that a series of professional and personal influences shape this expertise. As these findings are informed by conversations derived from one semi-structured interview with each research participant, they are somewhat limited in scope. Indeed, even though thirty-two hours of research material was constructed in the first phase, this attained limited new understandings regarding the attributes of expert praxis. Additionally, this research material does not enhance existent knowledge regarding the informants of therapist expertise.

In view of these restricted findings, the overarching themes and sub themes that were realized in the first phase of the study are summarized in this chapter. Although this précis format is at odds with the usual qualitative practice of reviewing segments of elicited text, this shortened format is implemented due to the 'thin' outcomes that emerged. Moreover, as the fundamental issue of the thesis question addresses what makes therapy work, the nature and informants of therapist expertise were considered a secondary investigative concern.

Overarching Theme 1: Cognitive, Emotional, Relational Expertise

Specific cognitive, emotional and relational qualities exemplify expert psychotherapeutic practice. Essentially, this finding highlights

influences that enhance expertise beyond mere experience. The study ascertains that experts proactively seek to develop their qualities and skills on an ongoing basis to broaden their proficiencies. Expert practitioners are open-minded thinkers who welcome new experiences and professional feedback as opportunities for growth. Moreover, experts are comfortable with therapeutic complexity, relying on their clinical wisdom and professional experience to respond to therapeutic uncertainty and ambiguity. In addition, experts are enthusiastic learners who privilege self-awareness in the pursuit of personal and professional development. Experts possess highly developed emotional qualities of receptivity, realness, emotional and spiritual wisdom and evidence a strong commitment to self-care. Finally, experts are thought to possess strong relational skills such as sensitivity and the ability to connect with others. Accordingly, these qualities enable experts to develop powerful alliances characterised by the capacity to challenge themselves and others. Thus, this complex notion of cognitive, emotional, and relational features is viewed as a substantive attribute of therapeutic expertise. Significantly, this phase of the study indicates the presence of these therapist attributions are likely to lead to positive client outcomes.

Discussion of Theme 1

The findings of this study share much in common with North American master therapy literature. Although a comprehensive body of international literature reviews expert practice (Chi, Glaser, & Farr, 1988; Dawes, 1994; Dreyfus & Dreyfus, 1986), this notion took some time to be recognized within the psychotherapeutic domain. Although multiple efforts to clarify the meaning of this construct have been made (Heppner & Claiborn, 1989; Kivlighan & Quigley, 1991; Martin, Sleman, Hiebert, Hallberg, & Cummings, 1989) this was not fully realized until a series of North American studies by Jennings and Skovholt (Jennings, Hanson, Skovholt, & Grier, 2005; Jennings, Goh, Skovholt, Hanson & Banerjee-Stevens, 2003; Jennings & Skovholt, 1999; Jennings & Skovholt, 2004).

In these investigations researchers identified the attributions of expert psychotherapists based on the statements of ten master clinicians

nominated by their professional peers as 'the best of the best' in their field. Although this purposive sample ranged in theoretical orientation, education, and experience, all participants were engaged in full-time private practice. Essentially, these findings led Jennings and Skovholt (1999, 2004) to establish a range of features that characterize therapeutic mastery. Accordingly, these traits are organized into a sequence of cognitive, emotional, and relational qualities that typify therapeutic mastery, numerous studies also regard them as aspects of expertise (Bennett-Levy, 2006; Eells, 1999; Meichenbaum, 2002). As both these notions are used interchangeably in this context, this implies that mastery and expertise are analogous concepts within the realm of psychotherapy praxis (Jennings, Hansonn, Skovholt & Grier, 2005). Therefore a brief overview of the cognitive, emotional and relational mastery identified by this study and its North American counterparts follows:

Cognitive, Emotional and Relational Mastery

In terms of the replicability of these findings, the West Australian outcomes regarding the nature of expert therapeutic practice are almost identical to the groundbreaking North American research of Jennings and Skovholt (1999). Both studies clearly identify the cognitive, emotional, and relational features of master therapists. Specific cognitive features identified by the North American and West Australian studies suggest that expert therapists are voracious learners who value cognitive complexity and ambiguity. Moreover, these individuals draw extensively from their accumulated wisdom based on professional and personal experience that informs their therapeutic interventions. In addition, expert therapists are insatiably curious, demonstrating a profound understanding of the human condition. Although these findings are clear and unambiguous, they parallel previous North American studies (Cummings, Hallberg, Martin, Slemon, & Hiebert, 1990; Dreyfus & Dreyfus, 1986; Hillerbrand & Clairborn, 1990; Kivlighan & Quigley, 1991; Martin, Slemon, Hiebert, Hallberg & Cummings, 1989). However, an interesting omission in the West Australian study centers on the notion of reflexivity. Although this practice is an established attribute of cognitive expertise in many of the North American studies

(Jennings & Skovholt 2004), there is no mention of this feature in the West Australian study. As the implications of this omission are significant, they are discussed later in this chapter.

Likewise, with regard to emotional mastery, this West Australian study identifies similar characterological features identified by the North American studies of Jennings et al. (2004). This ascertains expert therapists are emotionally receptive, self-aware, non-defensive individuals who are open to all forms of client feedback. Moreover they are mentally healthy, mature members of the community who attend to their self-care needs and emotional well-being as priorities. Expert therapists are also thought to have a strong awareness of their emotional health and how this affects the quality of their therapeutic interventions.

With regard to relational expertise this study as well as that of Jennings et al. (2004) determines that expert psychotherapists possess highly developed interpersonal skills. Invariably these stem from early life experiences within their families of origin. Specifically, both North American and West Australian investigations establish expert therapists develop exceptional relational skills from listening to and observing others from early in life. Accordingly, these experiences provide opportunities to develop interpersonal competencies that eventually enhance therapeutic praxis. Moreover the cumulative effect of these experiences suggests experts hold a number of important beliefs about human nature that enable them to build strong therapeutic alliances. Specifically, these proficiencies help them to provide safety and support within the therapeutic environment that supports their ability to respond to complex client problems and challenges.

In summarizing this overarching theme of cognitive, emotional, and relational competency, Jennings and Skovholt (1999, 2004) make the point that master therapists share much in common with Rogers' (1961) fully functioning person and Maslow's (1970) self-actualized individual. Three key features characterize these representations that include an increasing openness to experience, living fully in the moment, and increased trust in the self. Jennings and Skovholt also ascribe the status of senior therapist

to expert practitioners and attribute the integrity stage of Skovholt and Rønnestad's (1995) model of therapist development to their level of maturation. Furthermore Jennings and Skovholt posit master therapists are representative of Erikson's (1963) ego integrity stage of human development.

Thus in reviewing the West Australian findings and the master therapy literature, it is clear that many of the aspects of this local study match the North American criteria. Nonetheless, despite this limitation the West Australian study does enhance understandings regarding the interiority of expert psychotherapists and their capacity to privilege humanist ideals. Hence, although the local study fails to expand aspects of cognitive, emotional and relational expertise, it reveals an enriched portrait of the expert psychotherapist. The next stage of this discussion examines these findings that stress the advanced status of expert interiority.

Expert Therapists: Highly Developed Human Beings

This West Australian study determines that expert psychotherapists are highly functioning individuals who demonstrate optimal levels of human development that have little to do with specialist, declarative knowledge. Indeed Ryan and Deci (2000) postulate this occurs when individuals acquire competence, autonomy, and relatedness that advance self-motivation and mental health. Moreover this high level of internalized growth is characterised by an intensity of motivation that Winner (2000) describes as the "rage to master" (p. 163). These findings are similar to descriptions by Baltes and Staudinger (2000) that characterize the wisdom of individuals as "knowledge and judgment about the essence of the human condition and the ways and means of planning, managing and understanding a good life" (p. 124).

Interestingly, the findings of the West Australian study also match the attributes of ideal human characteristics identified by early descriptions of the humanist domain of psychology. Perhaps the most well-known exemplar relates to the portrait of the self-actualized individual articulated by Jourard and Landsmen (1980). This description lists fifteen

characteristics that are very similar to the attributions of expert psychotherapists. Specifically these include a limited sense of defensiveness; high acceptance of self and others; spontaneity and naturalness; focusing on problems outside the self; need for privacy and autonomy; recurrent feelings of appreciation; a sense of connectedness with the whole of humanity; close and loving relationships; strong ethical commitments; preference for democratic decision-making; a sense of humour; creativity and resistance to negative aspects of enculturation. Moreover these traits also resemble Roger's (1961) model of the fully functioning person.

In addition, the West Australian study also affirms that expertise does not encompass narrow skill development and micro-skill technique. Although this is identified by previous studies, it emerges in this study as a striking feature (Scatura, 2001). Contrarily, trainer participants in the first phase of the study stressed the importance of the relational capacities that typify expertise with comments like "experts have an understanding that it's the 'as if' relationship that counts". Essentially they were viewed as ordinary human beings who are modest and humble yet passionately committed to their personal development. It is interesting to note that the mean age of the nine psychotherapists identified as experts in Western Australia was 59.9 years. Surprisingly, only three were women whilst the remaining six informants were men. This contrasts with the research population in the initial American study by Jennings and Skovholt (1999) that consisted of seven women and three men. This difference is viewed as noteworthy and may be related to the cultural influences embedded in Western Australia. Accordingly, it is discussed later in this chapter as a significant feature that infers a number of implications.

Having critiqued the overarching theme of cognitive, emotional and relational expertise identified in the light of informed commentary, the next task of this review explores the various sub-themes and descriptive categories associated with West Australian therapeutic expertise. Thus a detailed exploration of the cognitive, emotional and relational features

identified as attributes of West Australian expert practice represents the next task of this discussion.

Sub-Theme 1.1: Cognitive Expertise

Specific attributions, identified collectively as the sub-theme of cognitive expertise, encompass the intellectual development and clinical acumen of expert practitioners. In particular, rich life experiences and superior emotional intelligence are identified as expert qualities. Accordingly, these features are thought to help experts to tolerate the presence of oppositional tensions inherent in psychotherapeutic praxis. In turn, these abilities are cited as attributions that empower experts to manage ambiguity, complexity, and contradictions effectively. In turn this facility supports experts in avoiding simplistic solutions and showing enthusiasm for problem-solving. Thus these qualities and attributions function as categories within the sub-theme of expert cognitive expertise. Accordingly, each of these components is discussed in detail in the following commentary.

Management of Ambiguity, Complexity and Contradiction

Expert psychotherapists are perceived to welcome ambiguity and complexity. Moreover the majority of participants expressed the belief that experts are stimulated by multi-faceted client problems. This category stresses that experts prize intricate therapeutic challenges as opportunities for growth. In constructing this premise a number of participants emphasize that experts adopt a 'not knowing' stance that represents a feature of mastery. Finally, this category underscores the capacity of experts to recognize contradictions and inconsistencies in client narratives and take advantage of these ambiguities to enhance therapeutic interventions.

Commitment to Learning

A second category of cognitive mastery portrays experts as individuals who display a deep commitment to life-long learning. This thirst 'to know' is generally accompanied by curiosity in all forms of human behaviour that manifests in therapy as an intense interest in client narratives. However although the inquiring stance of experts is stressed,

compassion and sensitivity is also viewed an integral feature of their listening quality.

Problem-Solving Competencies

The study stresses experts possess enhanced capacities to use both declarative and procedural knowledge. Specifically, they demonstrate masterful problem solving abilities, using humour and provocative strategies as techniques to challenge clients and resolve their difficulties.

Clinical Acumen

The capacity for clinical acumen is identified a key category of cognitive expertise. In clarifying the meaning of this notion, many informants refer to it as insight or acuity that encompasses a combination of cognitive and creative processes. Accordingly, this component is a key cognitive attribution that advances transformational changes in clients.

Discussion of Cognitive Expertise

This sub-theme affirms current research on therapist mastery identified by previous studies and informed commentary of Jennings & Skovholt (1999, 2004) undertaken in North America. Although four distinct cognitive categories of expert praxis are recognized in the West Australian study, they are similar to the three attributes of cognitive mastery identified by the North American research (Jennings & Skovholt, 1999; Skovholt & Jennings, 2004; Skovholt, & Jennings, 2005). The additional West Australian categories correspond to a love of learning and the importance of experience emphasized by a similar Singaporean study (Jennings, D'Rozario, Goh, Sovereign, Brogger, & Skovholt, 2008). However, unlike the North American and Singaporean position, the omission of therapist reflexivity is a significant variation. As the implications of this difference are substantive, its significance is discussed later in this chapter.

Nevertheless, apart from the feature of expert reflexivity, the overall thrust of the North American and Singaporean findings when compared with this West Australian sub-themes, reveals strong convergence. For instance, this study's cognitive constructs are similar to

those experienced by counsellors in Skovholt and Rønnestad's (1995) developmental model of therapist maturation. Essentially, the latter privileges an "embracing of complexity" (Jennings & Skovholt, 2004, p. 49) as aspects of cognitive proficiency. Furthermore the central precept of cognitive development identified by this West Australian study focuses on the ability to manage ambiguity and hold a not-knowing stance. This shares much in common with the Uncertainty-Certainty Principle of Professional Development espoused by Rønnestad and Skovholt (2003) that asserts optimal supervisory presentations are characterised by a searching stance in response to uncertainty. Moreover, Ward and House (1998) argue the professional growth of practitioners during supervision and training comes from "experiencing increased levels of emotional and cognitive dissonance" (p. 23). They assert that:

Counsellors are encouraged to reflect in the moment of action, when situations do not present themselves as given, and clinical direction must be constructed from events that are puzzling, troubling or uncertain (Schön, 1983). It is this recognition of discomfort in response to professional experiences that highlights the reflective learning process and....encourages supervisees to willingly explore dissonant counselling experiences (p.25).

Sub-Theme 1.2: Emotional Expertise

The findings of this study also establish that a number of emotional attributes characterize the praxis of expert therapeutic practice. In particular, this sub-theme indicates the receptivity of practitioners, commitment to emotional health, and awareness of the role of emotional competency point to the presence of therapist mastery. Specifically, therapist emotional mastery that emerged in this stage included receptivity, realness incorporating authenticity and genuineness, and emotional and spiritual growth. This took the form of enhanced self-awareness, acceptance of limitations, and the commitment to growth and self-care. Accordingly, details of each of these categories are explored as the next task of this review.

Receptivity

Emotional receptivity is perceived as quality of expert practice. In clarifying the meaning of this notion, one participant states that “experts are completely open and available to the emotional needs of others”. Another suggests the emotional receptivity of experts means they “take the experience of a session totally into their being”. Specifically, coding that classifies research material into meaning units such as emotional availability, the ability to recognize and accept the emotions of others, and mutual emotionality describes the emotional receptivity that legitimizes this category as a feature of emotional expertise.

Realness

The category of emotional realness emerges as a holistic concept that comprises a series of related therapist attributions such as compassion, empathy, authenticity, and genuineness. Essentially, the study ascertains this quality of realness emerges as a direct result of the therapist’s commitment to continually broadening their life experience. Thus the quality, depth, and continuity of therapist experiencing become the cornerstone of professional competence.

Emotional and Spiritual Growth

This category combines emotional and spiritual wisdom as a feature of emotional expertise. Participants emphasize that emotional and spiritual wisdom stem from seminal life experiences. Exploratory conversations suggest therapist emotional and spiritual challenges enhance their personal and professional insights.

Commitment to Self-Care

An important feature of this phase of the research establishes experts display a strong commitment to self-care. Participants indicate expert practitioners are keenly aware that the intense professional demands by clients pose potential threats to their welfare. Consequently, they incorporate self-care strategies to balance these stressors. These range from supervision, personal therapy, and physical exercise.

Discussion of Emotional Expertise

The sub-theme of emotional expertise acknowledges that expert West Australian psychotherapists demonstrate affective receptivity, realness, spiritual and emotional depth and a commitment to self-care. Specifically, the study determines emotional openness and availability together with expansive self-awareness are features of emotional expertise. These characteristics parallel the findings of North American studies that highlight the emotional attributions of master therapists (Jennings & Skovholt, 1999; Skovholt, 2005; Skovholt & Jennings, 2004). Moreover, both West Australian and North American studies postulate that personal therapy, peer consultation, and supervision are resources that master therapists utilize to improve this quality.

The Western Australian study resembles the North American research (Skovholt, 2005; Skovholt & Jennings, 2004) as it refers to emotional receptivity as self-awareness and non-defensiveness. Moreover the West Australian study adds a further dimension to expert receptivity as its notion of receptivity incorporates both emotional and relational features. Although this difference has little practical effect, it demonstrates the proximity of emotional and relational traits. Indeed although the domains of relational and emotional expertise are relatively new constructs in the field of mastery traditionally informed by cognitive attributions, this commonality underscores their growing significance (Jennings & Skovholt, 1999). Despite this arbitrary technical distinction, the remaining features of emotional expertise that emerged from this study match the North American studies (Jennings & Skovholt, 1999; Skovholt, 2005; Skovholt & Jennings, 2004). Namely expert West Australian therapists are mature, mentally healthy individuals who attend to their emotional, physical, and spiritual needs. Accordingly, this practice contributes to their high standard of professional competence

Sub-Theme 1.3: Relational Expertise

A number of relational qualities that inform the praxis of expert psychotherapists were identified. These include sensitivity in interpersonal

encounters, the ability to establish meaningful contact, and the capacity to challenge dysfunctional thoughts, feelings and behaviours. Accordingly, the next task of this discussion examines each of these categories.

Relational Sensitivity

The view of participants in the first phase of this study establishes that the relational sensitivity of experts frequently emerges early in life. Accordingly, this quality is the seed of sophisticated interpersonal skills experts manifest later in life as they develop professionally. Specifically, this sub-theme establishes expert therapists display exceptional talents in relating with others. In the context of therapy, this empowers practitioners to create environments in which clients feel safe and validated.

Primacy of Relational Contact

This importance of interpersonal contact and connection with another is underscored as an essential element of relational expertise. Indeed, the study ascertains that expert psychotherapists privilege the therapeutic alliance as the most influential determinant of client change. In particular, a number of participants minimize the importance of therapeutic modality, claiming the therapeutic relationship in some ways constitutes the therapy itself.

Capacity to Challenge

The final category of relational expertise concludes that the relational talents of experts empower them to challenge their own dysfunctional patterns as well as those in clients. Participants stated repeatedly this capacity derives from the willingness of experts to confront their pain.

Discussion of Relational Expertise

An important theme of this phase of the study indicates that expert therapists value meaningful relational contact as a major feature of the therapeutic alliance. This sub-theme of relational expertise implies that expert therapists display relational sensitivity and treasure meaningful contact as major features of the therapeutic alliance. Moreover, due to

their commitment to identifying and confronting dysfunctional behaviours, experts have the capacity to support and challenge themselves and clients. These attributions are similar to the relational expertise of master therapists identified in the North American studies (Jennings & Skovholt, 1999; Skovholt, 2005; Skovholt & Jennings, 2004). The most notable of these include the ability to engage with others intensely, demonstrate acute interpersonal perception, and exceptional relational acumen associated with accurate judgment and exceptional timing.

Implications of Theme 1: Attributes of Expertise

The first overarching theme of this phase of the study suggests therapeutic expertise is characterised by advanced human development rather than skill mastery. Accordingly this has profound implications for the domain of psychotherapy. This approach contends that personal characteristics that typify the interiority of expert psychotherapists match optimal models of human functioning. In effect, this means elements of therapeutic mastery are comparable to idealized human characteristics identified by humanistic psychology (Baltes & Staudinger, 2000; Ryan & Deci, 2000). Indeed Myers (2000) associates the qualities of happy people with the traits of expert therapists such as self-acceptance, personal, and professional satisfaction. Likewise Coan's (1989) optimal self posits high functioning individuals are characterised by five significant attributes. As these include competence, creativity, inner harmony, relatedness and transcendence, they correspond to the attributes of expert therapists identified by this study. Furthermore, expert psychotherapists are perceived to possess qualities of mind that have also been identified by previous research as attributes of therapeutic mastery (Jennings & Skovholt, 1999; Skovholt, 2005; Skovholt & Jennings, 2004). However, the realization that therapeutic expertise embodies "a period of becoming" (Skovholt, Jennings & Mullenbach, 2004, p. 140) rather than technique-development, raises substantive implications. Accordingly, as these relate to the whole domain of psychotherapy as well as the education of its trainees, the significance of these issues are addressed.

Firstly, the emergence of therapist cognitive, emotional and relational mastery challenges the rationale of existent psychotherapy training in Western Australia. Essentially, current precepts in the training of Australian psychotherapists favour the advancement of theoretical knowledge and technical competency informed by specific therapeutic frameworks. This privileging of modality is reflected in the organizational structure of the Psychotherapist and Counselling Federation of Australia (PACFA), a peak, self-regulating body that develops standards of counselling and psychotherapy practice in Australia. As an umbrella body, PACFA represents thirty seven professional associations and more than three thousand practitioners. Its commitment to unite the field of psychotherapy and counselling yet maintain the identity and purpose of individual member associations is paramount. Its list of member associations detailed in Appendix "H" indicates that, for the most part, psychotherapy training in Australia is informed by allegiance to specific therapeutic brands. Although university programs in the public sector adopt a broad approach, private training programs, that dominate the field, are generally restricted to a specific theoretical orientation. However findings in this first phase of this study infer this focus on technical mastery is misguided. Alternatively, it implies enhancement of trainee knowledge depends on the breadth and rigour of personal experience rather than informed by manualized skill instruction.

Secondly, although this study affirms previous research that cognitive competency is a feature of therapeutic mastery it determines that emotional and relational attributes are equally significant. Thus this change in emphasis has implications for the selection of future trainees as well as development of training objectives. Specifically, it raises questions about the criteria used in Western Australia to assess the suitability of psychotherapy trainees. At the present time trainees encompass clinical and counselling psychologists, psychiatrists, social workers, occupational therapists and generic counsellors. Although these candidates are chosen on the basis of interviews based on a wide range of criteria, the majority of tertiary training institutions select candidates on the basis of academic

merit. Although selection criteria of private training institutions are not always disclosed, there is a general assumption that academic qualifications are a paramount consideration. Hence this study's findings that emotional and relational attributes are features of expert praxis challenge this practice.

Additionally, this theme raises a series of questions that address the future of West Australian psychotherapy education. Specifically, the determination that cognitive, emotional and relational traits characterize expert practice calls for the development of appropriate admission criteria for psychotherapy training that takes account of these features. Moreover these findings challenge trainers to determine the most appropriate way to select trainees likely to develop these qualities. Furthermore this question leads trainers to ponder a further issue: namely what kind of training nurtures and facilitates the "ways of being" (Kottler, 2003, p.30) outlined by this theme?

Thirdly, apart from training implications, this overarching raises questions about the current zeitgeist of West Australian psychotherapy practice that privileges empiricalization (King & Ollendick, 2000), the rise of evidence based treatments (Chambless & Ollendick, 2001) and evidence based relationships (Norcross, 2002). Indeed, cautions articulated by Lichtenberg and Wampold (2002) have relevance to this issue. They assert that "it appears that 'common factors' and the individual therapist account for dramatically more of the variance in therapy outcome than do the particular treatments" (p.310). Accordingly, manualized development of reductionist treatments currently dominating the landscape of psychotherapy are at odds with the overarching theme of this study.

Fourthly, this study indicates that therapist maturation is a developmental process that emerges from the evolution of attributes that embody therapist mastery. For instance, the ability to tolerate ambiguity and complexity stems from years of therapist problem solving, commitment to learning, and a willingness to challenge oneself and clients. As indicated, these features characterize the cognitive, emotional and relational competencies of experts informed by experience and the motivation to

grow. However these attributes and influences have been outlined in previous models of therapist development. For instance, Rønnestad and Skovholt (1993, 2003) developed a theoretical framework that spans across the professional life span of therapists. This model emerged from a longitudinal, qualitative study that interviewed one hundred therapists who ranged from graduate students to professionals with an average of twenty-five years of experience. Accordingly, these researchers constructed a model of therapist maturation characterised by six distinct phases and fourteen related themes. As the last phase of this model, coined the senior professional phase, has relevance to this study's findings on therapist expertise, its major tenets are cited. Rønnestad and Skovholt's (1993, 2003) model of therapist maturation posits that therapists who evolve to the senior phase of professional development experience a continuous commitment to grow. They generally evidence a strong sense of self-acceptance and high levels of work satisfaction. Although they are competent in terms of work performance, they tend to be unassuming. This profile fits with descriptions that emerged in the first overarching theme gleaned by this West Australian study. Moreover many of the themes highlighted by Rønnestad and Skovholt's typify features of West Australian expert therapists. The most relevant are the commitment to life-long learning, human relationships and personal suffering. Within this context, professional development manifests as growth towards individuation affected by multiple sources that shape the experience of maturation as long, slow and erratic.

Fifthly, this finding has implications for research that investigates the determinants of effective therapy. As indicated in the literature review of this thesis many decades of research sought to identify what makes therapy work. Accordingly, studies have compared the effects of different therapies on outcome effects. Although these determined that modality has limited impact on client change, a significant sector of the research community still continues to espouse that only evidence-based treatments are therapeutically effective. Consequently Theme 1 challenges this stance as knowledge of modality is conspicuously absent as a feature of therapist

expertise. Specifically, even though cognitive proficiency is recognized, competencies such as comfort with ambiguity, problem solving abilities and clinical acumen qualify as tacit, procedural, 'knowledge of' rather than declarative 'knowledge that'.

Finally, the discovery of these attributions that exemplify expertise may have application to other professional groups. Indeed this study invites researchers in other disciplines to explore the applicability of the criteria identified by this overarching theme in other contexts. Although these notions principally inform further research in the domain of psychotherapy that has application for the training of skilled practitioners it may also have implications for the professional education of other professional groups. Nevertheless, despite the significance of this research that challenges current praxis in the training of West Australian psychotherapists, there are a number of limitations that negate the impact of this study. Accordingly, the final task of this discussion addresses these limitations.

Limitations of Theme 1

As the first phase of this study is a qualitative investigation of the opinions of Western Australian psychotherapists, its findings are limited by Euro-centric socio-cultural parameters. Specifically all informants who participate in the first phase of the study are educated in psychology, psychiatry, psychotherapy, social work and counselling in Australia, South Africa, the United Kingdom and the United States. Accordingly, their understandings are informed by Western culture, ethnicity, education and nationality. Therefore, although the researcher argues that findings of this research may have transferability to other therapeutic populations, given the grounded theory that emerged, these cultural limitations do have an effect on the validity of this assertion.

Secondly, as thirty two participants are interviewed in this phase of the research, the findings that emerge are limited by size and subjectivity. Specifically, researcher/participant co-construction of data is based on the perceptions of thirty-two participants and the understandings of a single researcher. Accordingly, Theme 1 is not an example of objectivist

empiricalization that typifies the dominant discourse of psychotherapeutic research. As an illustration of Dewey's (1933) practice wisdom that falls within the category of constructivist interpretative research, this finding is imbued with secondary status from the viewpoint of positivistic rationalist assumptions.

Thirdly, the generalizability of Theme 1 findings remains questionable as they are generated in an exploratory qualitative inquiry. Indeed, unlike the thrust of experimental, hypothesis-testing, the design of the first phase of the study is not intended to establish the qualities of *all* 'expert' psychotherapists. However, as the inquiry generates a specific grounded theory, it may be relatively easy to design a series of focused hypothesis-testing studies that experimentally verify the theory generated as the first overarching theme of this study. Accordingly, this could extend this theme to findings that apply to a larger range of people. Furthermore the fact that North American and Singaporean studies that predate this inquiry determine similar outcomes may indicate the broader application of the study.

Theme 2: Informants of Cognitive, Emotional and Relational Expertise

Although the first overarching theme of this study establishes that cognitive, emotional and relational qualities characterize expert praxis, a second overarching theme is identified. This ascertains a number of influences in the lives of practitioners inform the development of these attributes. Specifically, this outcome comprises two substantive sub-themes. The first sub-theme indicates that a number of influences drawn from the personal life of expert practitioners shape their therapeutic skill. These influences include factors such as family of origin, characterological features and spiritual and religious factors. The second sub-theme theme establishes specific professional informants are also major influences in the development of expert competencies. These include supervision, personal therapy, mentoring and personal acculturation. Consequently, the next task of this discussion examines each of these sub-themes and relevant categories that embody this second overarching theme.

Sub-Theme 2.1: Personal Informants

This theme demonstrate a series of personal factors inform of therapist expertise. These are identified as family of origin and the characterological features of compassion, curiosity, creative imagination and emotional intelligence. Moreover, a number of spiritual and religious factors are also identified as informants of therapist expertise. Accordingly, the following commentary summarizes these findings and discusses them in the light of the prevailing literature.

Family of Origin Influences

Early childhood influences have a profound impact on the development of expert praxis. A number of participants cite the early family life of experts as personal narratives characterised by suffering. Accordingly, participants wonder whether these difficult personal experiences enable experts to develop the aptitude to attune to clients experiencing emotional pain.

Characterological Influences

Certain personal traits and qualities of therapists influence the evolution of therapeutic expertise. These notions are identified as personal compassion, curiosity, creativity, emotional intelligence and reflective capacity. Accordingly, these components lead to the identification of characterological features assessed as attributes of expertise. Consequently each of the components is reported.

Personal Compassion

Participants bring attention to the personal compassion of expert therapists and wonder whether their deep awareness of human suffering enhances their therapeutic work. In particular, participants focus on the kindness of expert practitioners and reflect on whether this personal attribute influences their work. Moreover some participants reflect on whether the kindness and compassion of expert therapists are innate qualities acquired through the maturation process. Although this nature

versus nurture debate is not resolved, participants stress that compassion is an intrinsic feature of therapeutic expertise.

Curiosity

This component of characterological aspects identifies curiosity as an attribute of expert psychotherapists. Moreover, participants stress this attribute enables experts to attain a high standard of professional practice. Specifically, it is suggested that highly skilled practitioners are compelled to question, reflect, and wonder in pursuit of enhanced understandings. Indeed a number of participants attribute the expert with sleuth-like investigative skills.

Creativity

An additional concept that falls within the category of characterological influences establishes that expert practitioners possess innate creativity that manifests in the relational context of psychotherapy. In particular, numerous participants suggest experts use their imaginative capacities to augment their understanding of others. Alternatively, other participants postulate that experts rely on their creativity to improve their intuitive skills. Specifically, some stress that experts depended on their creative imagination to enhance their cognitive acumen.

Emotional Intelligence

It is determined that experts depend substantively upon their emotional intelligence to inform their therapeutic work. Accordingly, this feature represents a key component of the category of characterological features. Specifically, participants comment on the wisdom of experts, evident is their intuitive competency and clinical acuity. A number of participants also raise the issue of whether emotional intelligence is an innate capacity of expert performance or a skill developed through personal conditioning.

Spiritual and Religious Influences

Finally, as the last category of the sub-theme of personal informants, the study ascertains that spiritual and religious factors contribute

substantially to therapist expertise. One informant comments that spiritual experiences encountered early in life have a deep impact on therapeutic work. Other participants remark they were aware that a number of master therapists in Western Australia have strong religious affiliations that influenced their work significantly.

Thus in summarizing the effect of personal influences, it is clear that experiences that occur throughout the lifespan impact significantly on the functioning of experts. Specifically, family interactional patterns, parenting experiences, and personal traumas have a significant effect on therapist development.

Sub-Theme 2.2: Professional Informants

In addition to influences that emanate from the personal lives of experts, participants stress that factors stemming from their professional activities enhance the expertise of therapists. These include supervision, personal therapy, mentoring and cultural influences that, together, comprise the second sub-theme of the overarching theme, the informants of expertise. Accordingly each of these professional categories is reported as the next task of this commentary.

Supervision

Effective supervision is identified as a strong influence on expert development and therapeutic praxis. Indeed the majority of participants emphasize they understood that expert therapists consider practice supervision to be a life-long obligation. One informant speculates she believes that therapist skills in containing clients are significantly enhanced by their relationships with supervisors. Essentially, the majority of participants indicate that interactions with trusted supervisors are integral to the development of therapeutic expertise.

Personal Therapy

Personal therapy emerges as a potent informant of expert attributions. Essentially, participants suggest personal therapy enhances the ability of therapists to witness their internal and external reactions.

Specifically, a number of informants stress that personal therapy helps experts to develop a number of professional skills that advance client therapeutic movement. In particular, participants privilege the reflective proficiencies of expert therapists stating they are largely a consequence of personal therapy embraced by experts.

Mentoring

Mentoring is considered to be a significant determinant of expert clinical practice. Specifically, this study establishes that psychotherapists are substantially informed by experiences with mentors at important turning points in their careers. Moreover as a number of participants remark they have internalised these influences, mentoring effects are considered to be powerful and potent influences on the lives of experts. Over time, as the effects of these relationships become internalized, they impact significantly on professional competency. Thus a general picture emerges that suggests experts benefit substantially from strong, positive relationships with professional elders.

Cultural Influences

Diverse cultural experiences are identified as important influences on the lives of experts. Although all informants lead educational programs in psychotherapies informed by Euro-centric ideas, a number of trainers point out diverse cultural experiences have affected expert therapeutic practice. Specifically, participants reflect on the fact they consider expert clinicians are expansive thinkers who broaden their cultural perspective by engaging with a diverse range of enriching experiences. Accordingly, these encounters enhance their ability to work empathically with different populations.

Discussion of Theme 2: Personal and Professional Informants of Expertise

Much of this second overarching theme that outlines the determinants of therapeutic expertise confirms previous North American research. Consequently, this discussion confines itself to remarks that address the commonalities and differences between the current West

Australian study and the North American position. In a series of significant qualitative investigations Rønnestad and Skovholt (2001) explore influences that shape therapist development in North America. Specifically, these researchers examine data from sequenced, semi-structured interviews with ten master psychotherapists. Over time these researchers identify four significant learning arenas that inform therapeutic mastery: early life events, professional encounters, interactions with professional elders, and occurrences in adult personal life.

In comparing these findings with the current study, this commentary contends both investigations are strikingly similar in outcome. In effect, the personal and professional determinants of expertise that emerge in this West Australian study are comparable to the four learning areas ascertained in the North American research. However, unlike the first overarching theme of this study, this second overarching theme suggests the presence of important distinguishing features between the North American and Western Australian positions. These are discussed below together with remarks that address the implications and limitations of the West Australian study.

Personal Informants of Study and North American Research

The first sub-theme of Theme 2 identifies family of origin, character effects, and spiritual and religious factors as personal informants of therapeutic expertise. This finding parallels cross-sectional and longitudinal research in North America reformulated by Rønnestad and Skovholt (2003). This investigates the professional development of therapists and counsellors based on interviews with one hundred therapists and counsellors. Accordingly, these researchers have developed a six-phase model of therapist maturation, accompanied by fourteen emergent themes. This also determines that interpersonal experiences in the early life of master therapists impacts significantly on the progressive emotional growth of therapists. Likewise, the West Australian study evidences a similar conclusion even though the size of its sample of thirty-two informants is much smaller than the North American study. Moreover both studies ascertain that although childhood events of master therapists are painful, these experiences constitute significant influences on the development of

therapeutic mastery. Comments by Rønnestad and Skovholt (2003) reveal the effect of these difficulties:

During the second round of the senior interviews, eight of the senior informants that we interviewed told us how early family experiences had impacted them as professionals. It surprised us that for six of them the stories were primarily negative. The main family themes were psychological abandonment, a demanding achievement orientation in the family of origin, rigid and restraining child rearing practices, receiving conditional love from parents, and growing up in a family with a rule of no emotions. These experiences were seen as influencing professional life and functioning in various ways, such as selection of work role and theoretical orientation, therapeutic style and focus, attitude toward colleagues, experienced hardships, and ways of coping in practice (p. 34).

Although the West Australian and North American investigations suggest these negative experiences early in life enhance the professional competency of master therapists, these studies also stress this depends on whether therapists undertake psychotherapy or implement alternative means that process these difficult experiences. This approach affirms the notion of the wounded healer (Henry, 1966) as well as empirical studies such as the International Study of the Development of Psychotherapists Project (Orlinsky et al., 1999). The latter embodies an analysis of therapist development that demonstrates a strong nexus between self-reported qualities of negative early infant care and later professional functioning. It seems that when therapists who are wounded engage in long term therapy, they attain an increased ability to relate to clients, improve tolerance and patience and heighten awareness and credibility. Although these experiences are initially experienced as negative occurrences, as therapists mature these occurrences are transformed into opportunities for healing. Eventually, expert therapists come to the view these events enhance their long term growth. This is consistent with Nietzsche's edict that "the easy life teaches nothing" in which wisdom and suffering are linked. Thus, in

summary, the West Australian findings affirm the North American position regarding the impact of family influences on mastery development.

In comparing the attributes of North American master therapists with the attributes of West Australian expert therapists, it is clear the North American research is far more expansive in scope. However, many of the mastery features identified by Skovholt, Jennings, and Mullenbach (2004) are also identified in the West Australian study, albeit some slight differences. Specifically, characterological features of compassion, curiosity, creativity and emotional intelligence are identified as informants of expertise in the West Australian study. Nonetheless, the North American research perceives these influences as mere indicators of therapeutic mastery. Discussion of these features forms the next task of this commentary.

Compassion

Gilbert (2005) describes compassion in psychotherapy as the ability to be open to the presence of suffering in a nonjudgmental way coupled with the desire to relieve suffering. He argues that compassion is ignored in the psychotherapy literature because constructs like empathy and unconditional positive regard preoccupy the interests of research and informed commentary. Indeed, a review of the literatures suggests there is little empirical evidence that links compassion with therapeutic mastery (Rinehart, 2009) although some guidance is provided by the seminal research of Vivino, Thompson, Hill, Nicholas and Ladany (2009). This qualitative inquiry investigates the attributions of therapeutic compassion by interviewing fourteen therapists, nominated by their peers as compassionate clinicians. Accordingly, this ascertains compassion is a trait of therapists that enables them to connect deeply with human suffering. Moreover compassion was found to promote change in clients provided practitioners support the change process in an open-hearted, nonjudgmental manner. In examining the impact of compassion on effective therapy, Vivino et al. establish that compassion is a broader and deeper concept than empathy or unconditional positive regard as it has the effect of relieving symptoms. Moreover, although this study concludes

compassion is an innate feature of personhood, Vivino et al. argue this trait is likely to be enhanced by personal therapy, self-examination, and meditation. Thus, as the findings of this study view therapist compassion as an important feature of effective therapists, it gives some support to this West Australian study that regards compassion as an informant of therapeutic expertise.

Moreover the recognition that compassion is a characterological trait of therapists that facilitates expertise is also relevant to the spiritual and religious category identified by the study as a determinant of expertise. Although practices such as Christianity, Judaism, and Buddhism are considered to have had significant impact on the development of psychotherapy, Welwood, (1999) points to the dearth of empirical evidence that links spiritual or religious commitments with therapeutic mastery. However when considering factors that shape the development of therapist compassion, Vivino et al. (2009) establish that spiritual beliefs, experiences, and values impact significantly on the emergence of therapist compassion. Interestingly, the study also ascertains the development of therapist compassion emerges from a number of sources. These are similar to the personal and professional influences of therapist expertise and include personal therapy, family members, mentors, clients, professional training as well as the innate dispositions of therapists.

Creativity

Although this West Australian study views creativity as an informant of therapeutic expertise, this notion is virtually omitted from North American therapeutic mastery. However there have been efforts to discover the essence of creative therapy as distinct from therapist creativity. Whilst a full understanding of the attributes of creative therapy is beyond the scope of this research, the commentary that follows briefly describes this notion as a preface to understanding the notion of therapist creativity.

Few commentators attempt to describe the meaning of creative therapy. Hecker and Kottler (2002) view it as a process "born from frustration or the need for a solution" (p. 2) yet valued as a "thunderstorm

guiding the lightning bolts of creativity" (p.8). This approach views creativity as a synergistic combination of unique personality, imaginative process and emergent change. Additionally, Frey (1975) posits that therapy is a "creative enterprise in which therapist and client combine resources to generate a new plan" (p. 23) whilst Carson and Becker (2004) assert creativity is a prerequisite for effective therapy as it models the way therapists access their resources. In examining therapist creativity as distinct from creative therapy, Dewey's (1933) notion of practice wisdom is relevant. In effect, this knowledge domain infers that individual creativity stems from tacit knowledge extracted perceptually and conceptually from experience. Indeed researchers such as Lakoff (1987), Johnson (1987), and Gibbs (1997a) argue that individuals first come to know the world through experiential, bodily perceptions. They assert that tacit, experiential meaning-making methods provide a strong foundation that facilitates sudden insights. Accordingly, these flashes 'hit' with an immediacy that is more powerful than deliberate thoughtful analysis

Indeed, the idea that creativity arises from tacit, perceptual knowing receives substantial support in the psychotherapy literature. Bohart (1999) argues "it is the tacit, intuitive, experiential picking up of new meaning that is the ultimate basis of creativity" (p. 296). According to Gendlin (1964, 1969, 1996), creativity arises from a 'felt' sense of a therapeutic problem. Thus the intuition of therapists respond to this 'felt' problem tacitly and perceptually. This evolves in a number of contexts that include flow, style, and structure of client experience; flow, style, and structure of the evolving relationship between therapist and client; and the rhythm and flow in therapist experience. Hence creative therapists are required to be in tune with their inner experience, aware of their intuitions and insights. In addition, as part of their creativity, therapists are encouraged to look within for unexpected emotions, sudden recognitions, vague hints, and flashes of discomfort in response to client behaviours. Accordingly, when therapists pick up these intuitions or flashes they are required to elaborate on them. As this is a creative process, it calls for therapists to articulate their recognitions in words and symbols. Bohart (1999) contends this

involves checking flashes against their original intuition or insight, and then against their perceptions of client circumstances. If the insight fits, therapists are encouraged to ask client further questions and offer interpretations or suggest appropriate procedures. As they engage in this process and refine client responses to their questions, they become fully immersed in this creative process.

Having discussed the meaning of therapist creativity, it is apparent this influence may have a significant impact on the therapeutic encounter. However, as indicated, there is a dearth of research and commentary regarding this notion as an informant of therapeutic expertise. However this qualitative study does recognize its influence, although more confident parameters regarding its impact are recommended for future research.

Emotional Intelligence

Like therapist creativity, emotional intelligence is not with associated therapist mastery in the North American studies yet is identified as an attribute of West Australian mastery. Accordingly, this commentary presents a brief explanation of this notion prior to discussing its impact on the master therapy literature.

Darwin's concern with human evolution and the relevance of affect stirred initial interest in emotional intelligence. Over time several influential researchers recognized the importance of non-cognitive aspects of intelligence. In 1920 Thorndike coined the term 'social intelligence' to describe the skill of understanding people. Similarly, some decades later Wechsler (1952) described the effect of non-cognitive factors on intelligence. Essentially, he argued that models of intelligence are incomplete until these factors are fully understood. In 1983 Gardner introduced the idea of multiple types of intelligence due to the limitations of traditional definitions. However the initial use of the term 'emotional intelligence' began with Payne's ideas (1985) that were gradually expanded by Salovey and Mayer (1990). As these diverse perspectives bring varied meanings to this concept, the idea of emotional intelligence remains complex in range and scope. Thus there is substantial disagreement

regarding its definitional meanings, traits and processes. Therefore as the research of Salovey and Mayer is particularly pertinent to the field of psychotherapy, this discussion assumes their viewpoint in reviewing the findings of this study. Accordingly, an account of the understandings of these researchers is presented. Salovey and Mayer posit that emotional intelligence is “the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions” (p. 189). These researchers argue that emotions guide logical thinking and goal-oriented actions to enhance rationality. In describing emotional intelligence they conclude:

The emotionally intelligent person...attends to emotion in the path toward growth. Emotional intelligence involves self-regulation, appreciative of the fact that temporarily hurt feelings or emotional restraint is often necessary in the service of a greater objective (p. 201).

Moreover, Salovey and Mayer suggest negative or painful emotions are a necessary component of personal growth and postulate individuals feel joy and happiness to the extent they feel pain and sadness.

Thus, emotionally intelligent individuals accurately perceive their emotions and use integrated, sophisticated approaches to regulate them as they proceed toward important goals (p. 201).

These ideas are relevant to this study that contends emotional intelligence is an informant of therapeutic expertise. In effect, this stance asserts that emotions are instrumental in personal development provided that a mindset of working ‘with’ rather than ‘against’, emotions is adopted. In fact, Salovey and Mayer (1990) argue that sorting through emotions constitutes taking an inventory of cognitive processes that drive human behaviour. As this praxis enables individuals to assess their actions, it invariably leads to a process of self-discovery. Salovey and Mayer posit that such realizations are the basis of personal well-being and positive relationships with others. Thus the contribution of emotional intelligence that emerges from this phase of the study adds a new dimension to the

master therapy literature. Although some of its components such as an awareness of affect in self and other are identified by North American studies as attributes of expertise (Jennings et al. 2005; Skovholt & Jennings, 2005; Sullivan, Skovholt, & Jennings, 2005), emotional intelligence as an informant of expertise is confined to Western Australia. The implications of this finding are discussed later in this chapter. Having completed a critique of the personal informants of therapist expertise that emerge from this study, the next task of this discussion examines the professional influences that were identified.

Professional Informants of Study and North American Research

Ongoing supervision, personal therapy, mentoring, and cultural influences are identified as categories of the sub-theme of professional informants that shape their expertise. As with the personal factors previously discussed, this finding matches cross-sectional and longitudinal North American studies. However, although the West Australian study shares common characteristics with this research, there are a number of differences worthy of mention.

Supervision

This West Australian study ascertains that supervision is a powerful informant of therapeutic expertise. This stance affirms North American studies that stress supervision is a strong influence on therapist development. Within the context of psychotherapy supervision is viewed as the cornerstone of continuing professional development. In fact it is widely promoted as an essential aspect of ethical and effective therapy (Wheeler & Richards, 2007). Indeed, Grant and Schofield (2007) encapsulate its major functions as the acquisition of therapeutic knowledge; assurance of quality control and accountability; transmission of the culture of ethical practice, and the evolution of professional growth (Bernard & Goodyear, 1992; Loganbill, Hardy, E.. & Delworth, 1982). This formulation indicates that supervisors assume a number of roles that include didactic expert, technical coach, role model, and evaluator (Davidson, 2006; Johnson & Campbell, 2004; Watkins, 1997).

In general, the psychotherapy profession advocates the need for long-term supervision to ensure the development of competency, accountability, and critical self-reflection (Ellyard, 1998; Grant & Crawley, 2002; McMahon & Patton, 2002; Watkins, 1997). Moreover empirical research ratifies the importance of this practice in a number of international studies that ascertain therapists of varied professional backgrounds, in different countries, and at all career levels, rate supervision an extremely significant influence (Orlinsky, Botermans, & Rønnestad, 2001). Specifically, these studies assert that supervision is more valued by therapists than their experience of academic courses (Orlinsky & Rønnestad, 2005).

In a recent cross-sectional survey by PACFA, an organisation that represents three thousand psychotherapists and practitioners from all Australian States, Grant and Schofield (2007) assessed patterns and perspectives of long-term career supervision (Schofield, Grant, Holmes., & Barletta (2006). A number of valuable findings emerged that indicate Australian psychotherapists demonstrate a high commitment to ongoing supervision. Specifically, it ascertained that ninety-six percent of the three hundred and sixteen PACFA members who participated in the study were in receipt of ongoing psychotherapy supervision. This includes clinicians with twenty to thirty years of experience in practice. Moreover twenty per cent of this cohort received supervision weekly, whilst thirty-five per cent received it fortnightly. The researchers commented this was a high rate of compliance in comparison to previous studies in the United Kingdom and Australia that reported supervision rates ranging from 69% to 90% (Ashworth, Williams. & Blackburn, 1999; Gabbay, Kiemle, & Maguire, 1999; Orrum, 2004; Townend.lannetta, & Freeston,. 2002).

In terms of the mastery literature the West Australian study reflects the findings of the North American studies such as Rønnestad and Skovholt (2003) that establish experts display a strong commitment to supervision as they navigate the journey from novice to senior clinician. Moreover Jennings, Sovereign, Bottorff, Mussell and Vye (2005) determine that supervision is one of nine ethical principles that characterize the practice of

North American master therapists. This is in keeping with the West Australian findings that infer expert psychotherapists view supervision as an ethical obligation. Specifically, both the North American and West Australian studies highlight that experts continually seek formal and informal training opportunities to broaden their competencies.

Personal Therapy

Like supervision, the West Australian study acknowledges personal therapy has a strong influence on the development of expert therapists. Invariably, mastery is partly attributed to long-term analysis or some form of psychotherapy undertaken at various stages throughout the career of experts. Similarly, the North American position (Rønnestad & Skovholt, 2003; Skovholt et al., 1997) espouses that various interpersonal experiences have a profound impact on expertise. Although there is common agreement in the United States and Western Australia that substantive learning stems from the experiential and academic learning of therapists, both studies concede personal therapy becomes even more influential as therapists mature. In particular, both studies stress that wisdom and insight of therapists is enhanced as a direct result of personal therapy.

This position confirms previous empirical studies by Orlinsky et al., (2001) that investigate therapist development in general. Four thousand therapists from a number of countries were examined. They consistently ranked personal therapy as a significant influence on professional growth. Therapists who worked from twenty-five to fifty years and classed as senior practitioners rated personal therapy as the second most significant influence of their careers.

In a later related study by Orlinsky, Norcross, Rønnestad, and Wiseman (2005) that investigated five thousand psychotherapists from twenty countries, it was established that approximately four out of five psychotherapists were currently in receipt of personal therapy or had recently completed therapy. Ninety per cent of participants who had adopted an analytic frame claimed they were currently engaged in personal therapy or had received it in the past. In contrast, fifty-eight per cent of

self-described cognitive-behaviour therapists reported they had experienced or were currently receiving personal therapy. Finally, eighty to eighty-seven per cent of therapists who had accessed personal therapy were informed by eclectic theoretical orientations. These researchers also concluded that personal therapy is likely to enhance therapist interpersonal skills such as the development of compassion and empathy. Finally, they determined that successful personal therapy contributed to the ability to deal with the ongoing stresses of clinical work. Additionally, Norcross (2005), who collected research on the effects of personal therapy for over twenty-five years, added to this body of research by claiming that psychotherapists who engage with personal therapy acquire positive gains in a variety of areas:

It seems virtually impossible to have undergone personal therapy without emerging without heightened appreciation of the interpersonal relationship between patient and therapist and the vulnerability of a patient (p. 844).

Nevertheless, despite this plethora of evidence, there is considerable resistance to the inclusion of obligatory personal therapy in psychotherapy training. This negation is due to a number of considerations (Browne & Corne, 2004). Firstly, many authorities argue that personal therapy within educational contexts violates ethical guidelines (Borys & Pope, 1989; Clark, 1986; Macaskill, 1988; Truax & Carkhuff, 1967). Indeed McEwan and Duncan (1993) assert that it results in dual relationships and mandatory participation in activities that do not develop skill proficiency or declarative knowledge (Clark, 1986; Macaskill, 1988). Further objections include the potential for breach of informed consent, confidentiality, and a lack of freedom in therapist selection (Vacha-Haase, Davenport & Kerewsky, (2004). Although these challenges are largely overcome in the United Kingdom and the United States, personal therapy of trainees in educational contexts remains controversial in Australia (O'Donovan & Dyck, 2001). However it is interesting to note that although most graduate programs in the public sector do not include personal therapy as a feature of training, personal development programs that increase trainee self-awareness abound (Baer, 2003; Shapiro, Brown, & Biegel, 2007).

In a seminal review of the effects of personal therapy, Norcross (2005) challenges these objections in a series of suggestions that are relevant to the findings of this study. Firstly, Norcross advocates graduate programs in health care psychology select students for their commitment to interpersonal skill development in addition to academic scores. Secondly, Norcross encourages training institutions to demonstrate enthusiastic approval for psychotherapy and counselling trainees who engage in personal therapy. Thirdly, Norcross recommends training programs increase the availability of personal therapy for students by maintaining lists of local practitioners who offer reduced fees. Furthermore, he opts for appropriate referral to this resource with the understanding that the usual ethical standards of confidentiality and privacy are guaranteed. Fourthly, Norcross advises trainers and educators to model openness to personal therapy and self-development as an integral aspect of professional development. As many of the participants interviewed connected the value of personal therapy with the long term effects of positive mentoring, the latter is addressed as the final determinant to be reviewed by this discussion.

Mentoring

Although mentorship emerged as a category of the sub-theme of professional informants of expertise, this is viewed as less influential than supervision and personal therapy. Although this parallels the position elsewhere, it is important to note that very little research has been undertaken to investigate the relationship between therapeutic mastery and mentoring. Most research defines mentoring as a personal relationship in which a more experienced member of a profession acts as a guide, role model, teacher, and sponsor to a less experienced junior. In particular, mentors provide protégés with knowledge, advice, challenge, counsel, and support in their pursuit of becoming a full member of a particular profession (Clark, Harden, & Johnson, 2000; Johnson, Koch, Fallow, & Huwe, 2000). Johnson (2006), a renowned reviewer of mentor and supervision relationships defines mentoring as:

A personal and reciprocal relationship in which a more experienced faculty member [or clinical supervisor] acts as a guide, role model,

teacher, and sponsor of a less experienced student [or supervisee]. A mentor provides the protégé with knowledge, advice, counsel, challenge, and support in the protégé's pursuit of becoming a full member of a particular profession (p. 20).

Moreover Johnson distinguishes supervision from mentoring by making the point that they are not mutually exclusive but complimentary. Although mentoring emphasizes support, encouragement, advocacy, and collegial connection, supervision in psychotherapy comprises a distinct mandate for evaluation and gate keeping (Bernard & Goodyear, 2004).

Despite the paucity of empirical research, there are a number of benefits from mentoring that are generally accepted (Healy & Welchert, 1990). These include enduring enhanced personal relationships, achievement, and experience in the profession. Mentors provide protégés with direct career assistance, social and emotional support whilst serving as intentional role models. Mentor relationships are also viewed as increasingly reciprocal as the relationship unfolds. Finally, mentoring offers identity transformation to protégés and a safe harbour for self-exploration (Johnson, 2003, 2006; Kram, 1985).

In terms of the mastery literature, there are few guidelines with regard to the nexus between mentorship and expertise. Rønnestad and Skovholt (2001) posit that “senior therapists are profoundly influenced by early life experiences and professional elders or mentors” (p. 68). In a similar vein this West Australian study has also established that mentoring relationships are informants of therapeutic expertise.

In summarizing the categories and sub-themes of the second overarching of this study that identified the personal and professional informants of therapeutic expertise, this review compares these outcomes with a series of related North American authorities that have investigated the notion of therapeutic mastery. Although small differences between the West Australian and North American positions are identified, overall their findings are similar. However there are a number of significant differences that are worthy of mention. In particular, therapist reflection and the drive

for mastery are viewed as important attributes of expertise in the North American studies but these features are either marginalized or overlooked in the West Australian study.

Omissions of the West Australian Study

As previously mentioned, although the North American and Singaporean research postulates the ability of experts to reflect is an important feature of cognitive expertise, reflexivity is omitted as an attribute of expertise in this West Australian study. In addition, although the drive for mastery is a key characteristic and determinant of expert psychotherapeutic practice in North America, the West Australian research omits reference to this feature. Consequently, in view of these omissions and their implications within the wider Australian cultural context, this discussion reviews each of these notions in detail before critiquing the limitations and significance of the second overarching theme as a whole.

Reflection

Dewey (1933), the instigator of reflective praxis, defines reflective thought as “active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusions to which it tends” (p. 118). As this explanation lacks specificity Dewey expands on this notion by stressing the role of experimentation in the development of reflection:

In every case of reflective activity, a person finds himself confronted with a given, present situation from which he has to arrive at, or conclude to, something that is not present. This process of arriving at an idea of what is absent on the basis of what is at hand is inference. What is present carries or bears the mind over to the idea and ultimately the acceptance of something else (p. 190).

However Schön (1983) regards Dewey’s assertions as vague and divides the praxis of reflection into two separate activities. Schön’s approach posits that initially practitioners engage in reflection-in-action that involves ‘thinking on one’s feet’. This embodies looking to experience, with feelings, and attending to theories in use, building new understandings

to inform actions in a situation that is unfolding. Indeed Schön (1983, p. 68) posits that:

The practitioner allows himself to experience surprise, puzzlement, or confusion in a situation which he finds uncertain or unique. He reflects on the phenomenon before him, and on the prior understandings which have been implicit in his behaviour. He carries out an experiment which serves to generate both a new understanding of the phenomenon and a change in the situation.

Over time Schön asserts this process links to a secondary practice, coined reflection-on-action that enables therapists to explore previous actions and the events that informed their decision-making. Accordingly, this usually manifests in the form of questions that investigate practitioner thinking and how they influence action.

Within the field of psychotherapy Kuenzli (2006) posits that reflexivity means staying connected with oneself, whilst connecting with the client, and at the same time being able to conceptualize the work. Thus reflexivity is not a linear process as it invites other levels of meta-processes continuously. Furthermore Kuenzli distinguishes reflexivity from reflection by arguing that the former implies the necessity of action from an individual involved in reflection. Specifically, reflexivity also carries a relational value that is missing from the notion of reflection. Thus it refers to an inward and outward movement that is more than the sum of the two. Accordingly, it implies a constant change in the therapist's perspective that ensures it "remains uncertain of the certainties" (p. 17). Alternatively, Rennie (1992) posits that reflexivity is self-awareness and agency within that self-awareness. This means the ability "to think about thinking and feeling, to have a feeling about a feeling, to have a desire about a desire, and that this self-awareness flows into action." (p. 183).

In relating these notions of reflection to the question of therapist expertise, the North American studies determine that master therapists depend upon their reflexive capacity to process client experience (Rønnestad and Skovholt, 2001). Essentially, these findings indicate a

committed praxis of life-long therapist reflection informs therapist mastery. Yet the impact of reflection, privileged in the North American study, does not emerge as a feature of the West Australian study. While at first glance the variance between the North American and West Australian scenarios seems minor, it is significant as reflexive thought and action seems pivotal to cognitive, emotional, and relational mastery in North America.

In addressing this omission in the West Australian study, this may reflect design deficiencies or significant cultural differences that distinguish psychotherapeutic expertise in Western Australian from North American mastery. Alternatively, this distinction may suggest the need for further more specific research in this domain in Western Australia. In terms of design differences between the West Australian and North American research, the omission of reflection may arise as a consequence of the differing research populations. Whilst Jennings and Skovholt (1999, 2004) constructed their overarching theme of cognitive, emotional and relational mastery from the reflections of expert therapists per se, the first phase of the West Australian study collected research material from psychotherapeutic trainers. Although experts in the second phase of the study valued reflection as an informant of effective therapy, these trainer-participants in the first phase ignored its importance. As this feature is highly valued by expert therapists in West Australia and North America, what does this imply about the training of therapists in Western Australia? If educators in the field overlook or marginalize this facility, does this imply certain limitations in their training or does it reflect a deeper cultural difference between West Australia and North America? Accordingly these differences are examined in detail later in this chapter.

Drive for Mastery

Generally speaking, the North American literature suggests master therapists are aware of the complexities of therapeutic work and are deeply committed to addressing these difficulties (Mahoney, 1997; Schwebel, Schoener, & Skorina, 1994). Specifically, Rønnestad and Skovholt (1991, 2003) emphasize that expert therapists strive to master challenges that arise in their client encounters. Indeed, Skovholt, Jennings, and Mullenbach

(2004) stress these therapist abilities are similar to the competencies of gifted and talented individuals. Nevertheless, despite these findings the West Australian study omits reference to the drive to master as an attribute or informant of expertise. As this notion is such a consistent feature of the American studies, it is helpful to examine its meaning in more detail as a preface to reflecting on its absence in the Australian context.

Perhaps the first question to answer turns on what is traditionally meant by the term 'mastery'. Although responses within the general literature are diverse and inconsistent, Orlinsky's (1999) interpretation on the meaning of mastery is instructive. His critique centers on the relevance of two notions: the competencies of master teachers and the competencies of individuals who practice an art or science with exemplary proficiency. Specifically, Orlinsky contends these two related constructs imply a thorough knowledge of a particular subject matter or mode of practice. Mastery in teaching implies a systematic, articulate, theoretical kind of knowledge that can be clearly imparted by precept and instruction. Mastery in practice implies an encompassing, inventive, procedural kind of knowledge that can be modeled impressively for others or used as the basis for supervisory shaping of the practice of others.

In terms of the expert therapist literature the North American studies (Jennings & Skovholt, 1999) identify nine features that characterize the drive to mastery in the domain of psychotherapy. In comparing this position with the West Australian findings, it is clear that the first overarching theme of study establishes therapists are curious individuals who ask challenging questions in their professional work. However this attribute is distinguishable from the desire for mastery in terms of the definitions articulated by Orlinsky (1999). Essentially, the desire to attain competence and excellence identified by these authorities is far more expansive than therapist curiosity (Mahoney, 1997). Thus the drive for mastery fails to emerge as an *attribute or an informant* of expertise in the first and second overarching theme of this West Australian study. In commenting on this distinction, this discussion contends that acculturation specific to Western Australia may account for this difference. Although this variation may stem

from the tenets of local psychotherapy training, the pursuit of excellence could be more reflective of American cultural attitudes than the wider West Australian community. As with therapist reflexivity, this issue falls within the ambit of future research. Having presented and critiqued the second overarching theme of this study and its categories and components, the next task of this discourse highlights the implications and limitations of these personal and professional informants of therapeutic expertise.

Implications of Theme 2: Personal and Professional Informants of Expertise

In terms of the personal determinants of therapeutic expertise, this study raises a number of significant implications that are relevant for the training of therapists and the psychotherapy profession in general. Firstly, as compassion emerges as a potent determinant of therapeutic mastery, this poses interesting issues that pertain to the development of practitioners. For instance, important questions turn on the nature of compassion itself. Is therapeutic compassion an innate characteristic or can it be developed over time? If it can be developed, how might this be achieved? Moreover, could compassion be taught in training encounters anyway, or is it 'caught' from interpersonal connections with supervisors, mentors, or professional elders? If this is the case, what methods augment these opportunities? Moreover should compassion be empirically investigated as previous inquiry is primarily qualitative? Clearly matters require further consideration, discussion, and investigation.

Secondly, although creativity is recognized as a feature of practice wisdom (Dewey, 1933; Gendlin 1996), it is not overtly associated with therapist expertise despite intensive investigation of mastery attributions (Skovholt, Jennings, and Mullenbach, 2004). Nonetheless, it is clear that therapist creativity falls within the ambit of practitioner reflection-in-action based on a Schön's (1983) critique of empiricism. Specifically, in the tradition of Dewey (1933), Schön postulates that professionals encounter situations in which the empirical-rational-analytic model is not applicable. Accordingly, in Schön's view such situations require therapists to employ more creative approaches in their conceptualizations. Nevertheless, as the

empirical model is the dominant psychotherapeutic discourse, the view that creativity informs expertise has implications for the selection of psychotherapeutic trainees in Western Australia. Specifically, it raises questions as to whether creativity should be taken into account in the selection and education of trainees. Furthermore, as there are a number of definitions of creativity, how can this nebulous concept be operationalized into teaching objectives? As with compassion, relevant questions consider whether creativity is 'caught or taught' or viewed as an innate personal feature that cannot be conveyed in any form of education program? Clearly these issues require further debate and investigation.

Thirdly, as with creativity and compassion, emotional intelligence was found to inform therapeutic expertise even though this feature does not emerge from the prior mastery literature. However, as Salovey and Mayer (1990) link emotional intelligence with affective states that increase cognitive proficiency, emotional intelligence seems to resemble the cognitive attributes of mastery identified by North American studies. In addition, these studies also acknowledge that therapist features such as acute impersonal perception, focused self-motivation and the ability to be helpful to others are forms of emotional and relational expertise (Skovholt & Jennings, 2005; Skovholt, Jennings & Mullenbach, 2004). Accordingly, it is argued these attributes of expertise appear to resemble aspects of emotional intelligence. Thus, although the North American studies fail to identify these features as attributes of emotional intelligence, in actuality, perception, self-motivation, and relational proficiency are forms of emotional intelligence. In other words both the West Australian and North American studies appear to have determined that emotional intelligence may be 'Shakespeare's rose by any other name'. Hence, as emotional intelligence incorporates cognitive, emotional and relational qualities, it may be argued that it captures all the dimensions of expertise privileged by the master therapy literature (Jennings & Skovholt, 1999).

Fourthly, the issue of emotional intelligence raises questions with regard to the selection and education of trainees. Firstly, as with therapist compassion and creativity, if emotional intelligence informs expertise can

this competency be taught to trainees and novice practitioners?

Alternatively, if interpersonal proficiency is an integral aspect of this feature, how might professional educators convey this relational quality? Furthermore, as most West Australian university postgraduate programs in counselling psychology, clinical psychology, psychotherapy, and counselling admit students primarily on the basis of academic merit, how do the findings of this study with regard to emotional intelligence impact on this practice?

When considering the professional determinants of mastery it is clear that both West Australian and North American findings are similar. It seems that supervision and personal therapy are highly prized as informants of therapeutic mastery. However it is interesting to note that personal therapy is not viewed with the same importance as supervision in Western Australia. This may be rooted in the organizational structure that regulates the practice of psychotherapy in Western Australia.

With regard to supervision PACFA requires practicing members engage in ongoing regular supervision, irrespective of their status or experience (Schofield et al. 2006). When Grant and Schofield (2007) investigated rates of on-going supervision in Australia they established that most psychotherapists continue to pursue supervision long after training requirements have been met. Those who did not receive supervision cite three main reasons: being very experienced, consulting with colleagues when needed, and not seeing enough clients to warrant supervision. Factors related to higher frequency of supervision include more hours of client contact, hours of personal therapy, having university level training versus vocational, and being female.

In considering personal therapy as an informant of expertise, the situation is slightly less clear. As previously indicated, a study by Orlinsky, Botermans, and Rønnestad (2001) determined that over four thousand therapists ranked the interpersonal influence of clients, supervision, and personal therapy very highly. Personal therapy ranked above didactic experiences, such as taking courses and reading professional journals. Overall, more than three quarters of psychotherapists across multiple

studies found their personal therapy had a strong positive influence on their development, while fewer than three per cent reported that it had any negative impact (Orlinsky, et al. 2005). Nevertheless, despite this endorsement, there is a general professional consensus that personal therapy should remain a voluntary practice and not required in the same way as clinical supervision. However, in terms of training these researchers recommend that personal therapy be taken up by trainees. Alternatively, Orlinsky et al. suggest trainees engage in sustained participation in a self-exploratory peer encounter group. This finding reflects the previous research of Rachelson and Clance (1980), Morrow-Bradley and Elliott (1986) and Skovholt and Rønnestad (1995) that confirms interpersonal experiences are more influential than impersonal encounters such as coursework, seminars, and theories. In view of these studies it is surprising that the question of therapist personal therapy and its nexus with proficiency has not been researched with more rigour in Australia.

Likewise, as this study privileges mentoring as an influence on therapist expertise, this commentary suggests there may be a case for determining whether this praxis requires greater emphasis in the West Australian psychotherapy profession. Indeed a series of studies in North America postulates that mentoring provides multiple benefits of mentor and mentee. In terms of the mentee, these include greater productivity and eminence in the field; higher levels of skill development and competence; greater networking and engagement with colleagues; stronger professional confidence and identity; more career opportunities, and even higher levels of psychological health. With regard to mentors, benefits include satisfaction in enhancing skills in helping someone else to grow; opportunity to reflect on own practices; growth of ego integrity and community recognition (Hollingsworth & Fassinger, 2002; Johnson, 2006; Johnson, 2007; Johnson & Huwe, 2003; Liang, Tracy, Taylor, & Williams, 2002; Tenenbaum, Crosby, & Gliner, 2001).

Reflexivity and Drive for Mastery

While at first glance the variance between the North American and West Australian scenarios seems relatively minor, it reflects significant

cultural differences. This is particularly relevant to two important features of expertise marginalized or completely overlooked by both overarching themes of this study: therapist reflexivity and the drive for mastery. As the North American studies view the ability of therapists to reflect as an *informant* of therapist mastery, it may be assumed that this proficiency is highly prized in the United States (Jennings & Skovholt, 1999). Moreover, the reflexive qualities of therapists are perceived as evidence of effectiveness by a vast number of North American explorations that reviewed therapist competency generally (Jennings, Goh, Skovholt, Hanson, & Banerjee-Stevens, 2003). By way of contrast, this Western Australian study does not name it as a feature or a determinant of mastery. Although a detailed examination of this difference transcends the parameters of this study, some cursory comments about the meaning of this omission may be helpful.

As indicated, the omission of reflection may be due to design differences in the research populations of the West Australian and Northern American studies: the former comprised trainers and educators whilst the latter were identified as experts in their field. Nevertheless, the fact that trainers and educators failed to mention the importance of reflexivity may say something about the broader cultural context of Western Australia or the fact that West Australian trainers are out of step with praxis considerations of real-world environments. Accordingly as these considerations constitute options for further research this commentary limits itself to raising a series of relevant questions that may be taken up later for this purpose.

Firstly, given that Dewey (1933) and Schön (1983) are American theorists, the primacy they give to reflection as an expression of practice wisdom may be more relevant to North American culture than Western Australia. Secondly, as questioning constitutes an integral feature of reflexivity, the tendency for personal inquiry may illustrate the North American mindset more than West Australian tendencies. Thirdly, it is important to question whether North American psychotherapy training and professional development focuses more on encouraging reflexivity than its

equivalent in Western Australia. Specifically, in North America, where reflexivity emerged as an important attribute of cognitive mastery, its educators and professional gatekeepers may give higher priority to this capacity than their West Australian counterparts. Alternatively, in Western Australia it may be that its technique-oriented training institutions are more likely to privilege micro-skill development than reflexive praxis. This may account for the omission of reflexivity. Fourthly, Schön's imperative to professionals to reflect on matters, both during and after action (Schön, 1983), may be less relevant to the psyche of West Australians than to North American consciousness. Fifthly, it is important to consider whether the exclusion of reflection in the West Australian study reflects wider community attitudes that do not implement reflection, questioning, and challenging as much as their American counterparts. Finally, could this difference in reflexivity mean that the North American cultural context encourages reflection more than the Western Australian experience? Essentially, do members of the broader North American population feel more comfortable in adopting strategies of reflection towards self and others more than the West Australian wider community? If so, is this tendency a product of prevailing, implicit power structures that distinguish the practices of each of these cultures? As these questions are beyond the scope of this study, it is hoped that consideration of these issues will inspire future discussion and exploration.

The second difference between the West Australian study and North American findings concerns the willingness of therapists to strive for mastery. In the North American context Skovholt, Jennings and Mullenbach (2004) espouse that master therapists consider meaningful and rewarding psychotherapy a consequence of their determination to master professional work (Guy, 1987; Skovholt & Rønnestad, 1992). Indeed participants in a number of research studies refer to the desire of expert therapists to seek challenge, strive for excellence, and seek opportunities to expand their professional and personal growth (Jennings et al., 2005). However this quest is not mirrored by the West Australian study as it fails to find that the drive for mastery is either an *attribute* or *informant* of therapeutic expertise. As

this conclusion is at odds with previous North American findings, it is possible that striving for mastery is a cultural precept informed by contextual considerations. Essentially, this distinction suggests acculturation specific to Western Australia accounts for this difference. Whilst this variation may stem from the tenets of local psychotherapy training and professional development, alternatively, the pursuit of excellence may be more reflective of American cultural attitudes than the West Australian community. Accordingly this discussion poses a number of hypothetical questions that address the quest for mastery and its nexus with the wider West Australian population.

The first query considers whether the drive for mastery is reflected in West Australian education. Although there are no specific studies relevant to Western Australia, cross psychology research posits that North American students give more emphasis to achievement, competence, and conformity than Australian students (Feather, 1998). Moreover, it seems North American students are more in favour of rewarding high achievers than Australian students (Feather & Adair, 1999). Alternatively, Australian students underrate these values, delineating prosocial values such as egalitarianism and the welfare of others as more important (Feather, 1993). Indeed Peeters (2004) comments on Australian culture and its critique of the phenomenon described as the 'tall poppy syndrome'. In clarifying the meaning of this notion, common usage suggests this to be a pejorative term, popular in the United Kingdom, Ireland, Australia, Canada and New Zealand. In effect, the tall poppy syndrome refers to the practice of criticizing successful individuals due to their talents or achievements that distinguish them from their peers. In commenting on this construct in the context of student values and behaviours, Feather (1998) posits that although North American students are especially prone to favouring the reward of tall poppies given their emphasis on achievement. Specifically this finding reinforces the view that American culture is distinctive in having a stronger emphasis on individual achievement and the importance of recognizing and rewarding success. However the position is slightly different amongst Australian students. Although Feather concedes that Australian

students are less likely to opt for rewarding achievement than American students, interestingly, his findings reveal that Australian students do not favour the fall of tall poppies any more than American students. In addition, in a review of Australian and Canadian managerial values, Wolak (2009) points out a later study by Feather and Adair (1999) that compares Australian and Canadian attitudes toward achievement. As their results confirm previous research, Feather and Adair stress they could not confirm “the commonly held view that Australians are distinctive in wanting to see tall poppies cut down to size” (p. 56). However they add the proviso that, despite both samples showing similarities in personal self-esteem and value priorities, there are some variations consistent with their theories that could reflect the effects of culture. Specifically, Wolak summarizes the comparative values of the Canadian and Australian samples and posits that Canadians are relatively more concerned with achievement than Australians whilst the latter emphasize social egalitarianism more than Canadians. Additionally, this view of Australian/North American differences in tall poppy attitudes is also consistent with the results of a culture-level analysis reported by Schwartz (1994). This research establishes that, whereas Australia and North America are similar on most culture-level value dimensions, the latter have a higher mean importance score on mastery whilst Australia had a higher mean importance score on harmony. Thus, in view of these differences in the general population, it is conceivable these differences are likely to impact on psychotherapy praxis. Ultimately, as with therapist reflexivity, it is hoped that these questions may lead to further academic discourse and future research.

Limitations of Theme 2

In considering the limitations of the second overarching theme of this research phase comments made in regard to the first overarching theme are equally applicable. Moreover the study does not discriminate between expertise and mastery. As this issue was not part of the study’s initial research objectives it has not been included in this commentary. Furthermore this phase of the research suffers from a lack of depth that derives from the experience of one short semi-structured interview with

informants. Consequently research material that reflects on the meaning of expertise is relatively superficial and banal. Moreover although a semi-structured research protocol was designed to elicit research material from participants, this was limited in scope. In retrospect, it may have been advisable to implement an unstructured conversational interview with informants to attain richer material. Finally, in terms of the methodology used to determine the findings of this first phase of the study, full reliance is placed on Schön's (1983) rationale of reflective praxis. As indicated in previous chapters this is informed by exploratory concerns that derive from the subjectivity of participant and researcher and their intersubjective construction of data. This explicit and tacit knowledge is a consequence of the parallel dynamic of participant reflection-on-action and researcher reflection-in-action. Thus this qualitative approach is essentially practice based research and does not meet the positivistic norm of rationalist objectified investigation that is embedded in previous attempts to ascertain the traits of expert psychotherapeutic expertise and its informants.

Having completed a review of the first phase of this study, the next chapter is devoted to critiquing the major thrust of this research - uncovering the determinants of therapeutic effectiveness. Accordingly this second phase of the study is informed by Schön's (1987) views of the reflective practitioner that challenges educators to reconsider the role of technical knowledge versus "artistry" in developing professional excellence. Schön describes how professionals make sense out of situations that are complex, uncertain, unstable, unique, and value-conflicted. In these situations, professionals cannot apply their technical knowledge of how to deal with unambiguous situations. Instead, complexity and uniqueness spark reflection-in-action and much of professional mastery is knowing-in-action. This embodies our tacit ability to perform with skilled intuition.

Summary of Themes 1 and 2

This chapter focuses on the overarching themes that emerge from the first phase of this study that examines understandings of trainer psychotherapists regarding the meaning of expert psychotherapeutic practice. Two overarching themes that identify the attributes of expert

praxis and the informants of these tenets are realized. The first finding establishes that West Australian expert psychotherapeutic practice is characterised by cognitive, emotional and relational competence. Moreover, this conceptualisation shares much in common with North American findings conducted by Jennings and Skovholt (1999, 2004). However although the reflective capacity of experts are considered an important attribute of therapeutic mastery in North America, especially in the cognitive domain, reflexivity is not viewed as a feature of West Australian expertise. This distinguishing feature may be a result of the research design of the latter study, or alternatively, it may reflect a wider, more significant cultural difference between North America and Australia. Perhaps the impetus to question and reflect does not sit comfortably with the Australian psyche? Alternatively this omission of reflection may indicate that educators and trainers in this context who are generally focused on micro-skill development do not consider this to be an important feature of therapeutic practice.

The second overarching theme of the first phase of this study highlights the determinants of expert psychotherapeutic practice. Unlike the first overarching theme, significant differences between the West Australian and North American position are identified. Personal informants of West Australian expertise include family of origin influences, characterological and spiritual and religious factors. With regard to characterological informants, the West Australian study emphasizes the role of therapist compassion, creativity and emotional intelligence in the development of mastery. As all three qualities do not feature in the North American studies, or elsewhere in the mastery literature, it is suggested that future research focus on a richer exploration of these notions. However, the identification of these personal characteristics has significant implications for the training of psychotherapists.

The focus on compassion, creativity, and emotional intelligence as informants of expertise suggests that it is who the therapist is, as a human being, rather than what they know from their propositional knowledge, that signifies therapeutic mastery. Essentially, this finding highlights the tension

between *techne* and *phronesis* as discussed in the prologue of this thesis. Although elements of both paradigms are apparent in the propositional and procedural knowledge of psychotherapeutic practitioners, the implicit understandings of human beings conveyed through the qualities of compassion, creativity, and emotional intelligence denote mastery. Thus it may be argued that the informants of therapeutic expertise stem from the practice wisdom of the individual. However this raises further issues as to whether such attributes can be taught in training institutions. This begs the question, are these qualities developed as a result of the life factors that influence the individual or their inherent facticity?

To some extent these questions are answered by the professional determinants of expertise identified by this study. Essentially, they postulate that personal therapy, supervision, and mentoring are substantive influences on the development of therapeutic mastery. Accordingly, these findings have significant implications for the professional development of psychotherapeutic practitioners as well as novices and students in training. Although these remarks have direct application to Western Australia, it is submitted this study raises questions that pertain to therapeutic mastery generally. These include to what extent do professional training institutions such as universities and private programs endorse mentorship and personal therapy? Although supervision is recognized as a necessary practice requirement in many psychotherapeutic educational and practice domains within and beyond Western Australia, why is the position with regard to mentoring and personal therapy much more equivocal? Perhaps this difference may also be viewed as the application of *techne* and *phronesis*? Indeed, as Schwartz (2010) contends, if universities are now the centre of technocracy training, does this mean that *phronetic* notions such as mentoring or personal development fall outside its realm? If so the question arises can this form of practice wisdom be taught anyway? If so... where and by whom? Or is it just simply a matter of coming to terms with the idea that expert proficiencies of psychotherapists cannot be 'taught' but are just simply 'caught'? Hopefully this research will encourage other studies to explore this issue more closely.

Chapter Three Schematic Outline (Part A)

Phase I: Features of Expert Psychotherapeutic Practice

Findings: Overarching Theme & Associated Sub-Themes

Overarching Theme 1: Advanced cognitive, emotional & relational skill characterize West Australian expert therapeutic practice

Similar to North American findings: West Australian experts are highly developed human beings like Rogers' fully functioning person, Maslow's self-actualized individual & Erikson's (1963) ego integrity stage

Sub-Themes

1.1 Cognitive expertise: WA experts comfortable with ambiguity, complexity & contradictions whilst demonstrating commitment to learning & problem-solving revealing advanced clinical acumen

Similar to North American findings however omission of therapist reflexivity in West Australian context is a significant variation to previous findings

1.2 Emotional expertise: WA experts develop strong receptivity, realness, emotional & spiritual growth & strong commitment to self-care

Parallels findings of North American studies highlighting emotional attributions of master therapists

1.3 Relational expertise: WA experts possess relational sensitivity, advanced abilities in relational contact & capacity to challenge

Comparable to the relational expertise of master therapists identified in North American studies

Implications

- i. Themes & sub-themes infer therapeutic expertise requires "a period of becoming" rather than technique-development
- i. Substantive implications:
 - Therapeutic mastery = advanced human growth rather than skill sophistication challenges zeitgeist of therapy training highlighting theoretical orientation & manualized skill development
 - Themes & sub-themes infer emotional & relational competencies just as significant as cognitive skill
 - Emotional & relational competency represents call for trainers to ponder what kind of experiences facilitates "ways of being" in therapist development. Is a shift in training outcomes required?
- i. Theme & sub-themes at odds with manualized reductionist treatments dominating psychotherapy.
- /. Why is reflexivity omitted as a cognitive attribute of West Australian experts?
- /. As the drive for mastery, present in North American findings, is also omitted in West Australian findings, what inferences may be drawn from this?

Chapter Three Schematic Outline (Part B)

Phase I: Informants of Expert Psychotherapeutic Practice

Findings: Overarching Theme & Associated Sub-Themes

Overarching Theme 2: Personal & professional influences inform cognitive, emotional & relational attributes of West Australian expert psychotherapists: parallels North American findings

Sub-Themes

2.1. Personal informants include family of origin, character effects & spiritual and religious factors: additional characterological traits of compassion, creativity & emotional intelligence identified raising a number of significant questions:

- If compassion is a determinant of mastery, can it be taught? If so how?
- Does creativity fit with dominant empirical model of evidence based praxis?
- As creativity is a feature of Schön's practice-in and on-action could this model be highlighted in therapist training?
- What is the meaning of creativity anyway and how might this be advanced within the context of training?
- As interpersonal proficiency is an integral aspect of emotional intelligence, can this be developed in the context of therapeutic training? If so how?

2.2. Professional informants include supervision personal therapy & mentoring that are equally applicable in North American studies

Limitations of Phase I

- Small sample size of study with Eurocentric bias and limitations of Western Australian cultural locale

CHAPTER FOUR

PHASE TWO FINDINGS: WHAT MAKES THERAPY WORK?

Out of intense complexities intense simplicities emerge
(Winston Churchill, 1954)

The findings and implications of the second phase of this study are reported in this chapter. This reveals the determinants of effective therapy gleaned from the subjective understandings of nine expert West Australian psychotherapists. As discussed, this research population emerged from a blind, peer nomination procedure undertaken in the first phase of this study. Accordingly, three overarching themes and their associated sub-themes based on practitioner wisdom are identified as the informants of effective therapy. Broadly speaking, participants ascertained that client internalized change together with aspects of client and therapist personhood shape effective therapy. Accordingly, to facilitate reader understandings, research material that illustrates these findings is presented and discussed in the light of informed commentary. However, these de-contextualized exemplars are not presented as explanatory justifications for conclusions drawn from this study. They are not intended as data but reflect a broader, holistic analysis of thematic patterns. Essentially, these emerged from a contextualist analysis of meaning derived from verbal and non-verbal communication between participants and the researcher.

Overarching Theme 1: Internalized Change Informs Effective Therapy

As leading empirical researchers like Duncan, Miller, Wampold and Hubble, (2010) continue to investigate what makes therapy work investigation into client and therapist factors persists. The weight of empirical studies consistently shows the average person undertaking some form of psychotherapy is better off than eighty per cent of individuals who do not undertake any form of treatment (Lambert & Ogles, 2004; Wampold, 2007). In recent evidenced-based studies that examine the treatment of depression, Minami, Wampold, Serlin, Hamilton, Brown, and Kircher (2008) establish clients attain outcomes comparable to those in randomized clinical trials. Alternatively, in practice-based research that examines treatment for depression in real-world clinical environments, Stiles, Barkham, Mellor-Clark, and Connell (2008) compare cognitive-behavioural therapy (CBT), psychodynamic therapy and person-centred therapy. Accordingly, they report a large positive effect size when compared with results gleaned from similar randomized clinical trials. Nevertheless, despite comparable evidence affirming the value of psychotherapy, speculation continues about the informants of effective psychotherapy. Moreover, this quest is enhanced by the abiding belief that specific treatments targeting specific problems are the active ingredients of therapeutic success. Nevertheless, as Duncan, Miller, Wampold, and Hubble, 2010 point out, evidence that affirms this belief is conspicuously missing: “Bluntly put the existence of specific psychological treatments for specific disorders is a myth” (p. 28).

Additionally, this quest is heightened by inquiries into the actual nature of change itself. Accordingly, the first overarching theme of this chapter reveals the multidimensional nature of change and links with effective therapy. Specifically, this study ascertains internalized, second order client change is evidence of effective therapy. Indeed, the majority of participants in this second phase of the study stress that effective therapy is evidenced by transformational, internalized client change. As the research population in the second phase of the study represents proponents

of depth therapy, the majority do not consider amelioration of client symptoms is, of itself, indicative of effective psychotherapy. Thus, the excerpts that follow, derived from practitioner wisdom, demonstrate the kind of change associated with effective psychotherapy.

Research Excerpts

When I think about what works in psychotherapy I'm not talking about teaching patients how to manage symptoms... like anxiety or depression. I don't think conscious efforts bring about change. Mostly what works emerges through unconscious processes that happen in the room....in patients...in me....and in the space in-between us...So the actual symptoms clients bring usually lose their hold as they discover...often by accident, that their lives are more satisfying and meaningful. They begin to notice they are reacting differently....they're less defensive, more open and aware than before.

This excerpt reveals that client internal change is considered evidence of effectiveness. Specifically, the tone of this statement implies client characterological changes are considered evidence of effective therapy. In contrast, client external change, in the form of behavioural adjustments and symptom relief is viewed as less substantive. Moreover, the passage implies intrapsychic and interpersonal processes and the 'space' in-between (Gerrard, 1994) within the therapeutic dyad inform inner change. Accordingly, the first passage infers effective psychotherapy is evidenced by internal change in the characterological structure of clients. In addition, understandings in this passage are enhanced by the research extract that follows. This contends effective therapy is an iterative generative process occurring throughout the whole psychotherapeutic encounter:

It's a mystery really... when I think about what happens in therapy.....The changes clients makethey're not usually changes they choose. So when clients tell me how they went home after a session and did this and thatand then they had some kind of major breakthrough I'm always a little skeptical.....I'm not sure change happens like that. Clients don't always

recognize they're doing things differently.... rather it just creeps up on them... by surprise...it might be some kind of opening... a receptivityor readiness that wasn't there before...and it shows up in the therapy hour so that we both notice it ...So we explore and expand on this to bring it fully into the here and now....and this process repeats itself again and again...It's this kind of transformation that is evidence of effective therapy.

This excerpt reveals change processes occur sporadically in a succession of micro-events that lead to multiple shifts in the internal world of clients. Consequently, these movements function collectively to activate the kind of characterological changes cited in the previous excerpt. Similarly, these enactments arise independently of conscious volition as a direct result of the collaborative engagement of therapist and client.

Discussion: Internal and External Duality

In line with empirical evidence, the first overarching theme of this study asserts that effective psychotherapy is associated with change. However there is less support for the view that effectiveness is limited to client internalized change (Duncan et al., 2010). Although theorists posit change is the primary goal of psychotherapy (Carey, Leontieva, Dimmock, Maisto, & Batki, 2007), there are conflicting views about the quality of this change and the mechanisms that shape it. One school of thought, advocating externalized change evidences effective therapy, centers on modification of symptoms and acquisition of constructive behaviours. Indeed, Prochaska and DiClemente (1982), the first researchers to develop a pan theoretical model of therapeutic change, look solely to external changes as proof of effectiveness. This view of change, derived from multiple psychotherapies, is applied to a variety of addictive behaviours with beneficial results. This integrative approach, coined the transtheoretical model of therapeutic change (TMTTC), details how clients acquire constructive behaviours or modify problem symptoms. As this stance underscores the importance of client decision-making, it stresses intentional change impacts on social practices such as cessation of smoking, drug and alcohol abuse, diet, and stress management (Flay, 1985; Velicer,

Laforge, Levesque, & Fava, 1994; Velicer, Richmond, Greeley, Swift, & Redding, 1992).

Similarly, other therapies are specific forms of psychotherapy that resolve symptoms. For instance, the eight-phased model of EMDR developed by Shapiro (1995) implements a structured approach to overcome trauma derived from specific life events. The emotional freedom technique (EFT) developed by Craig (1997) is an alternative psychotherapy that purports to manipulate the body's energy field. Despite their success, critics view these theories as pseudoscientific suggesting their success stems from traditional cognitive components. Nevertheless, despite empirical support indicating client change, there is considerable reluctance to accept these theories as bone fide treatments. This stems from the fact that ordinary language cannot describe the operation of these interventions with ease. Therefore researchers, drawn to sense-making explanations, prefer to focus on cognitive benefits such as placebo effects, distraction from negative thoughts and the presence of receptive listeners as informants of success.

However, despite the symptom-reduction orientation of these therapies, numerous psychotherapy scholars postulate that internalized change is the focus of psychotherapy. Therefore these views limit evidence of effectiveness to client internalized change. This stems from the history of psychotherapy that privileged the corrective emotional experience (Alexander & French, 1946) and the internalization of client/therapist interactions as the focus of intervention (Sullivan, 1953). Indeed, these conceptualizations relate to Ferenczi's (1926) ideas of a new beginning and Balint's (1979) primary love as informants of effective psychotherapy. Specifically, these notions rest on the belief that positive experiences between client and therapists compensate for deficits in client early relationships. Accordingly, these interactions bring about internalised client change by re-directing "fixated developmental processes" (Jørgensen, 2004, p. 525). Although this stance is rejected by more current views that explore the determinants of therapeutic change, it highlights the primacy of client internalised change as evidence of effective therapy.

A more current position that espouses the importance of internalized change is fostered by the notion of mentalization. Developed by Fonagy, Target, and Gergely (2000) this view posits that mentalization, reflexivity, and the ability to interact with others are evidence of client internalized change. According to these researchers the emergence of a theory of mind, coined mentalization, forms the basis of the ability to understand, make sense of, and anticipate behaviours and reactions of others. Essentially, by attributing thoughts, feelings, and intentions to therapists, clients are able to understand their own behaviour. Thus mentalization enables individuals to “read,” understand, and make sense of other people’s minds and “predict and explain other people’s actions by inferring and attributing causal intentional mind states to them” (Fonagy, Gergerly, Jurist, & Target, 2002, p. 347). Accordingly, this capacity to reflect on the behaviour of others enables individuals to understand their own mental states and the subjective meanings of their feelings. Indeed Holmes (2001, p. 28), refers to this reflective function as a version of the traditional psychoanalytic notion of insight. This internal versus external duality and its nexus with change is enhanced by another form of duality coined first and second-order change. Therefore, this construct is explored in relation to effective therapy.

First and Second-Order Change

Drawing on family systems theory Lyddon (1990) describes first-order change as a process that fails to alter an essential feature of the structure of a person or system. Accordingly first-order change is associated with problem-solving and symptom relief. Hence, theories such as the transtheoretical model of change, EMDR, and EFT are likely to fall within this first level of change. Thus this kind of change is operationalized by this thesis as external change. In contrast, Lyddon (1990) perceives second-order change as altering the fundamental nature of a person or system. In effect, the internal structure is changed to the extent that the system is permanently redesigned and reshaped. Thus this order of change operates at a different level to first-order problem resolution and symptom reduction. Indeed, Fraser and Solovey (2006) argue this deeper layer of change leads to the development of insight, ability to confront issues, and

evolution of new perspectives in regard to problems, the world, and the self (Hanna & Ritchie, 1995).

Although research examining second-order change is relatively recent, this commentary contends numerous theoretical and anecdotal descriptions of this construct characterize the annals of psychotherapy (Bugental, 1987; Jung, 1933; Malone & Malone, 1992; Maslow, 1967; Rogers, 1961). More recently Hanna, Giordano, Dupuy and Puhakka, (1995) have investigated second-order change events using a phenomenological design that reveals rich descriptions of this change experience. Indeed informants in this study determined that the term “transcendence” best describes their experience of second-order change. Accordingly, Hanna et al. portray this form of change “as moving beyond, or stepping outside a set of perceived restrictions, confines, or limitations” (p. 146). Ultimately, these researchers conclude that agency and empowerment within the individual are associated with transcendence, the essence of second-order change. Consequently, it is argued that characterological changes referred to in previous research as inner change and transformation resemble the notion of transcendence (Jennings 1993; Pizzi, 1990). Additionally, as transcendence shares much in common with the process of transformation stressed by participants in this study, a brief discussion of transformation as an indicator and a determinant of effective therapy is the next task of this commentary.

Transformational Psychotherapy

Most disciplines regard internalized change as a necessary element of transformation (Ferguson, 1980). Indeed research that investigates the process and outcomes of transformation has a long history in the behavioural and health sciences. For instance, Stern (1993) argues personal transformation within psychotherapy is viewed as an evolutionary process that enables individuals to see themselves in new, expanded ways. Jung (1912) invested psychotherapy with a transcendent function that leads to personal, spiritual and social transformation. More recently, Siegel (2010) combines research into neurobiological science, attachment theory, and interpersonal psychotherapy to study personal transformation through the

plasticity of the human brain. In line with these efforts, Goodson (1977) claims transformation in psychotherapy produces change that involves a “person-becoming or a person-in-process” (p. 5). Similarly, Wade (2002) postulates the crux of personal transformation involves release from fixed belief systems to enlarged views of reality termed ‘expanded states of consciousness’.

However, in a contrary view, Miller and C’de Baca (2001) proclaim clients who change in the context of psychotherapy do not generally experience transformation. They argue that instead of dramatic change, therapists are more likely to observe a series of steady micro-shifts marked by sighs, verbal expressions and physical indicators as indicators of client change. Bien (2004) supports this view, arguing the emergence of client change is generally slow and tedious. Nonetheless, Hayes, Laurenceau, Feldham Strauss, and Cardaciotto (2007) challenge Miller and C’de Baca and Bien, highlighting that nonlinear, discontinuous transformational change equates with effective therapy. Prigogine and Stengers (1984) propose “most of reality, instead of being orderly, stable, and equilibrial, is seething and bubbling with change, disorder, and process” (p. xv). Essentially, Hayes et al. contend that individuals experience deep internalized change as a result of destabilization that occurs in the context of emotional arousal, accompanied by processing and meaning-making.

Hence, despite the findings of this West Australian study that suggest internalized transformational change is a determinant of effective psychotherapy, this is not fully accepted. Although clearly, some form of change is an outcome of effective therapy, its extent and quality are uncertain. Indeed, whilst this study, based on practice wisdom equates effective therapy with internalized, second-order change, a large body of empirical evidence counters this thrust. Specifically, this contends external change, in the form of behaviour modification and symptom relief, also indicates the presence of effective psychotherapy. Thus, in terms of the available evidence, the position is somewhat contradictory.

Nonetheless, despite the findings of this study privileging the link between second-order internalized change and effective therapy, it seems

that both internal and external change is accepted as evidence of effective therapy. In attempting to explain this discrepancy, it is suggested that design features of this study may be at fault. Specifically, the research population in the second phase of this study was composed of participants who were identified by peer review as experts in their field. Coincidentally all expressed a commitment to in-depth psychoanalytic, relational and humanistic psychotherapy. Conceivably, as this orientation may have enhanced their predilection for inner client change, it could account for findings that privilege second order internalized change as evidence of effectiveness.

Sub-Theme 1.1: Enhanced Sense of Self Supports Client Internalized Change

Although the first overarching theme of the study identifies client internal change as evidence of effective psychotherapy, a number of participants elaborate on the nature of this feature. Specifically, five informants highlight the emergence of a new sense of self as indicative of client change. Consequently, enhanced self-representation is considered a sub-theme of this overarching theme. This underscores the link between effective treatment and client change. Some of the responses that identify this notion are detailed in the commentary that follows.

Research Excerpts

When I provide opportunities for patients to develop a caring part of themselves by gaining a deeper understanding of their functioning... then I can say I've done my job! It means therapy has helped them accept themselves more....and of course...this is easier said than done! When people come to therapy their view of themselves is usually critical and condemnatory. But when they show a willingness to honour themselves in ways that weren't possible before therapy....something alchemical happens.

The thrust of this passage indicates increased sense of self is associated with inner change. Specifically, the emergence of a new self-representation functions as both an outcome and determinant of effective

psychotherapy. This excerpt stresses the function of therapists in facilitating client change in self-representation. Furthermore, it infers the strength of the therapeutic relationship and the quality of therapist skill enables clients to develop a benevolent sense of self. In particular, this passage stresses client identity is a direct consequence of both influences. Additionally, the quote emphasizes improvements in client self-worth and acceptance as informants and outcomes of this process.

Accordingly, the next extract offers an optimal description of the therapeutic process that leads to emergence of the client's enhanced sense of self.

The healing process is difficult to describe. As our relationship deepens and therapy progresses.... clients start carrying bits of me inside them... I become an internalized object they draw on to grow more robust parts of themselves.... So when they're confronted with challenges they ask themselves "What would my therapist do right now?" I guess...in a way...they become dependent on me.....and this is actually very helpful....for a while.... until they become stronger in themselves.

Essentially, this focuses on the healing effects of the therapeutic relationship and the role of the therapist in the inner life of clients. This account reveals the power of the interpersonal, specifically the potent function of therapists that are internalized by clients, symbolically, as a gatekeeper to positive change. Although this passage addresses client dependency in the initial stages of psychotherapy, it refers to its temporary nature and the benefits this brings in client's healing journey. Even though the passage does not refer directly to client autonomy that emerges from this process, it alludes to increases in client emotional strength as a determinant and outcome of effective therapy.

Discussion: Positive Change in Self-Representation

An emergent hypothesis in psychotherapy outcome research proposes that positive changes in client self-representation constitute a key outcome of successful psychotherapy (Blatt, Wiseman, Prince-Gibson, & Gatt, 1991). Self-representations and object-representations are concepts considered

central to an increasing number of psychotherapeutic approaches. Whether referred to as 'schemas', 'scripts', or 'mental models', these inner images are viewed as templates that guide behaviour and affect (Arnold, Farber, & Geller, 2000, p.449). Essentially, self-representations constitute ideas of personhood that range from specific body attitudes to more generalized understandings of personality type (Schafer, 1968). In addition, as human beings are "capable of thinking about [themselves] in many different ways at any given moment" (Greenberg, 1991, p. 171), these representations may be widely contradictory or highly consistent. Furthermore, as the human experience constantly changes, self-representations evolve continually.

Moreover, a significant body of research postulates individuals construct self-representations and object-representations simultaneously as they differentiate from aspects of relationships with significant others that have been internalized (Atwood & Stolorow, 1980; Behrends & Blatt, 1985; Mahler, Pine, & Bergman, 1975; Schafer, 1968). Traditionally, theories of internalization emphasize differentiation, individuation, and increasing independence. This results in what is a "separation-focused" model of development (Blatt & Blass, 1990). However, recent models of internalization tend to highlight interdependence or reciprocal attunement rather than separation (Stern, 1985). Nevertheless, in both cases, internalization of these significant relationships is considered to "contribute decisively both to the manner in which representations of self and other are affectively valued and to the functions such representations serve for a given individual" (Geller, Cooley, & Hartley, 1981, p. 126). Essentially, this body of research suggests client internalization of therapist qualities and aspects of their relationship enhance client self-views with respect to physical, emotional and characterological attributions.

Nexus between Therapist Internalization and Client Self-View

Research indicates clients are more likely to view themselves in benevolent and self-accepting terms at the end of therapy (Geller & Farber, 1993). Undeniably, self-acceptance is a goal of most brands of psychotherapy, especially those that are psychoanalytic, existential, or

humanistic. Indeed, Rogers (1957) asserts the necessary and sufficient conditions of therapeutic change facilitate client natural movement toward self-actualization and self-acceptance. According to Rogers, the therapist's task is focused on the expression of positive regard when clients view their beliefs, thoughts, or actions as unacceptable. Although Greenberg (1996) agrees with these ideas, he suggests that self-affirmation is more a result of a dialogical, interpersonal process:

When one exposes oneself... in all one's vulnerability and the messiness of one's experience, or view of oneself as ugly, to another, and discovers that the other does not flinch or reject but empathically prizes and understands, the experience is overwhelmingly affirming.....It provides a significant boost to one's ability to accept oneself and grow (p. 257).

Thus, this enhanced sense of self is viewed as an indicator of the first theme of this study that ascertains inner change is akin to effective psychotherapy. Furthermore, the study also establishes that an enhanced sense of self is an informant and outcome of effective therapy. This reflects a pan theoretical approach that underpins diverse forms of depth therapy exemplified in psychoanalytic, person centred, humanistic, and existential approaches.

Sub-Theme 1.2: Client Objective and Subjective Change

Numerous participants espoused that effective psychotherapy is characterized by two kinds of client change: subjective and objective change. Hence the study recognizes these features of client change embody a sub-theme of the broader overarching theme of client internalized change. Accordingly, the excerpts that follow reveal the meaning and effect of these two kinds of change.

Research Excerpts

I think change evolves in two stages. When patients participate in therapeutic processes that lead them to experience themselves more positively, they become aware something changes..... this is the first stage. Then when patients realise their lives are less problematical because

they get feedback from the outside world that they're functioning better, this functions as external proof of their internal change.

This passage makes reference to two types of change that indicate the presence of effective psychotherapy. Initially, changes that clients perceive from their subjective experience are highlighted. For instance, clients suffering from anxiety may notice their worry diminishes during the process of therapy without apparent reason. Essentially, this extract suggests this kind of change occurs prior to observable change evidenced by external indicators. In contrast, the next passage refers to situational changes, apparent through observable, objective assessment. This kind of change may manifest as a measured assessment of client ability or an observable change that emerges as a result of client awareness.

People come in and they're focused on fixing some sort of issue outside themselves... like a relationship or an unpleasant work situation...but they're much less aware of the internal dimensions of their difficulties... Generally they seem to have very little idea about how they might be contributing to the problem. So unless there is some sort of inner change that supports any effort at situational change, the therapy experience has a relatively modest effect. For example I am thinking of a client who is a professional woman who I saw with her husband in couple therapy. Although they ended up separating she came back to do some individual work to handle child care arrangements with her husband. When she began therapy she was chronically depressed, suffering from low self-esteem and with very little sense of her own value....and these problems showed up in her familial and work relationships. She felt easily put down, inadequate and worthless and was very hopeless and helpless about life. I saw her weekly for about three years.... and by the time she left therapy she'd overcome many of her problems. Her sense of self-worth increased and her depression lifted. She became empowered at work and responded to her family in a more cheerful, proactive manner. She began to handle her relationship with her ex-husband in ways that ensured the stability of their child care arrangements. There was real growth in her sense of self.....and this became apparent from the way she functioned in the world.

Although subjective and objective change depicted in these examples resembles the overarching theme of internal and external change discussed previously, they are quite different. Whilst the latter refers to emergent internal changes of client interiority, subjective and objective change focuses on different kinds of perception that evidence change. Thus, unlike internal and external change, subjective and objective change does not refer to the re-shaping of the structure of an individual or entity. Rather, these notions reflect the positioning of the narrative that attests to the reality and quality of change (Polkinghorne, 1988). As this positioning affects the saliency of this theme, a close examination of subjective and objective change follows.

Discussion: Paradoxical Subjective and Objective Change

Whilst this sub-theme focuses on differences between subjective and objective change supported by a long history within psychotherapy, a critical evaluation of this duality points to its paradoxical nature. To illustrate the absurdity of differentiating between objectivity and subjectivity in this context, this discussion explores the interplay of these components within the clinical vignette included in the second passage discussed above. This suggests that subjective changes experienced by the client at the cessation of therapy included increased self-esteem, personal agency, and empowerment together with a new sense of confidence and optimism. In terms of the objective changes, these included improved interpersonal skills that manifested in enhanced functioning in work and familial contexts informed by more productive and harmonious relationships. As the precepts of subjective and objective change are institutionalized within the psychotherapeutic domain, this discussion presents a brief account and critique of this construct.

History of Subjective and Objective Change in Psychotherapy

Within psychotherapy, subjective change is traditionally devalued as unscientific due to its link with client phenomenology (Greenberg, 1986). As this positivistic stance has dominated discourse for the last four decades, Bugental (1987, p. ix) refers to the subjective realm

as a “psychological terra incognita” that fosters self-awareness, inventiveness, and autonomy (Bugental, 1992). Although this approach reflects humanistic and existential orientations, the subjective dimension of human change has only recently entered the wider sphere of psychotherapy (Hogan & Smither, 2008).

Initially, humanistic frameworks led by Rogers (1957) championed recognition of subjective, individually constructed views of experience and the critical role of emotional experiencing (Grindlinger, 2003). The core features of Rogers’s client-centred psychotherapy value the person and feelings expressed in the here and now. This approach argues that when clients and therapists honour client subjectivity, this realizes positive, meaningful, therapeutic benefits (Geller & Greenberg, 2002). Additionally, existential psychotherapies, promulgated by luminaries such as May (1950), Bugental (1987), and Frankl (1984) espouse psychotherapy functions as a response to inner conflict. Client concerns that include the inevitability of death, freedom and its attendant responsibilities, isolation, and the search for meaning characterize this existential angst. Accordingly, this subjectivity forms the landscape of existential psychotherapy (Spinelli, 2002; Yalom, 1980).

In recent years a relational turn has begun to counter the stranglehold of rationalist objectivism within psychotherapy (Mitchell, 2004). This development has spawned various new therapies that privilege subjective client change. Theories such as the relational cultural theory of Jordan, Kaplan, Miller, Stiver, and Surrey, (1991) and Stolorow and Atwood’s (1992) intersubjectivity typify this movement. Acceptance and commitment therapy, a new form of behaviour therapy (Hayes, 2004), and narrative therapy embody relational perspectives that honour subjective change (Botella & Herrero, 2000). Although these varied approaches recognize that positive change in client self-views are indicative of effective therapy, the long-established dominance of measurable, objective evidence as proof of change continues. Indeed, Schulenberg (2003) speculates this is likely to remain as long as the objective realm examines the describable, predictable, and controllable aspects of human behaviour.

Nevertheless, although Bugental's (1992) stance contrasts with the health sciences tradition that favours measurable evidence (Jacobson & Truax, 1991), it does not discount the importance of the objective. Specifically, Bugental argues that to understand human behaviour, both subjective (inner awareness) and objective (outward/observable) dimensions are relevant (Bugental & Sapienza, 1992). Yet, although Bugental (1992) posits that 'true' knowledge is "objective, value-free, stable and separate from the world around us" (Winkler, 1973, p. 120), this statement is open to dispute. Additionally, the 'scientific' experimental model with its fundamental premise that researchers abandon attitudes and beliefs to search for objective, valid truth enhances this questionable assumption.

The Illusion of Objective Truth

Despite positivistic assumptions to the contrary, in actuality the existence of a value-free truth is illusory (Winkler, 1973). As the ideals of psychotherapy are inevitably tied to the prevailing culture, its ruling theories, institutional constraints and valued information, they cannot be classified as objective. Indeed Pepper's (1942) contextualist world hypothesis confirms that historic events are composed of interconnected activities where parts are not separate from the whole. Essentially, this epistemological stance postulates that subjective change and objective change cannot be separated from one another or from the context in which they exist. Specifically, within the field of psychotherapy McLeod (1999) mirrors this view in pointing out that contextual issues are largely ignored in theory, research and practice. Thus, increased attention to factors such as the physical and emotional climate of the therapy room and the cultural beliefs and values of both client and therapist are likely to contribute to the creation of more responsive and effective psychotherapeutic practice.

This acceptance of the indivisibility of subjective and objective change, acknowledges the paradoxical nature of this identified theme. As Polkinghorne (1988) contends there is no such thing as unbiased knowledge because knowledge is always grounded in a set of intellectual assumptions and constitutive interests. Hence this implies that objective knowledge or

objective change does not exist within the human and social sciences. Indeed change effects are inevitably subjective. Thus the subjective/objectivity duality identified by this theme must be viewed as paradoxical. Given this recognition, perhaps the celebration of subjective change may be a more appropriate nomenclature.

Summary of Theme 1: Client Internal Second-Order Change

Essentially, the majority of informants ascertained that client internal change is an informant of effective therapy. Indeed, these findings imply that client internal change represents an essential and necessary component of successful therapy. Moreover, new forms of client self-representation, the presence of second-order subjective and objective change are also attributes and determinants of client internal change. Accordingly, these features are acknowledged as sub-themes of the overarching theme of internalized change. However, despite the efficacy of this theme and its related notions, these findings may be viewed as questionable when deconstructed in the light of empirical research and informed commentary. Specifically, this critique argues the privileging of internal change as an indicator of therapeutic success is open to dispute as numerous studies establish, unequivocally, that external behaviour change also confirms the effectiveness of psychotherapy. Likewise, the duality of subjective and objective change is illusory as numerous constructivists have demonstrated change is almost always subjective within the human sciences. Finally, the appearance of a new sense of self, considered to be a function of effective therapy and positive change, is also misleading. Although depth therapies proclaim that development of a benevolent, caring sense of self represents a therapeutic goal this aim is irrelevant to other psychological orientations such as cognitive behaviour therapy. Hence, although client internal change evidenced by enhanced client self-representation and awareness of difference is said to contribute to effective therapy, this assessment is likely to be challenged as erroneous.

Having determined that effective therapy is equated with some form of client change, the next stage of this discussion examines the significant elements that inform these effects. Essentially, these constitute

identifiable influences contributed by clients and therapists. In addition, specific interpersonal processes that manifest within the therapeutic environment also play an important role. Consequently a cross-section of research excerpts that illustrate the factors and processes identified by expert participants as informants of effective therapy are presented. Moreover these are discussed and critiqued as overarching themes of this study in this chapter as well as the following chapter. Initially, the role of clients in effecting change is explored as the second overarching theme of this phase of the research.

Overarching Theme 2: Contribution of Clients

The importance of the client's contribution to effective psychotherapy is a long- established principle. Indeed Orlinsky, Grawe, and Parks (1994) claim "the quality of the patient's participation in therapy stands out as the most important determinant of outcome " (p. 361). Seligman (1995) posits clients who are actively involved are more likely to benefit from psychotherapy. Bergin and Garfield (1994) conclude "the client more than the therapist implements the change process" (p. 825).

Although empirical evidence has long established the significance of the client's role, the nature of this contribution continues to be the subject of investigation. Indeed expert informants in this study highlighted a variety of ways that clients contribute to effective therapy. Specifically, they stressed the role of client symptoms, psychological mindedness, reflexivity, and openness to change. Accordingly, these determinants are viewed as sub-themes of the second overarching theme: client contribution. Hence, the next task of this commentary examines the role of client symptoms in the realization of effective therapy

Sub-Theme 2.1: Client Symptoms

Although participants referred to the importance of the intersubjective field, six respondents stressed that symptoms are informants of effective therapy. Specifically, they emphasized their role in moving towards client second order change. Accordingly, the first passage

below stresses the positive role of symptoms within the therapeutic encounter and their impact on effective therapy:

Research Excerpts

You have to accept what is offered and enhance it...usually in non-verbal, experiential ways. Clients give out clues. They're active and creative so I respond to these clues...to get beneath them....to see what's really there. Body movements, facial expressions, emotions...all these things tell me about the problem. And, more often than not, I use humour provocatively, to exaggerate symptoms. That way we both get a handle on the real issues...that are often hidden...even from clients themselves. So symptoms help me get to the cause....that's why I don't believe in CBT....it misses the point. Symptoms are the map that brings me home...to where client problems begin.

This excerpt demonstrates that clients are potent determinants of change as their behaviours, thoughts, and feelings influence the therapeutic landscape. However this also stresses the significance of aware, receptive therapists who attune to these phenomena developing provocative ways to benefit from them. Moreover, client symptomology is privileged as a valuable tool that embodies specific knowledge pointing the way to therapeutic change. Indeed, the following passage that features a clinical vignette, advances understandings in regard to client symptoms and their potential to resolve difficulties

People are like plants...There's a life-force in them that wants to grow...but unless the plant is fed and watered, it doesn't. And this shows up as a kind of stuckness in the client....And nothing can be done...it doesn't matter which therapy you use...nothing works unless you find the source. And when you do.... you nourish and nurture the life-force and the plant begins to grow again. And even though this life-force can't be measured... it's there...otherwise why would people come to therapy? Something within them wants to grow. So when clients bring their whole awareness to this stuckness, it opens up the doorway to change.

In addition the participant provided the following example to indicate the role of symptoms:

One woman came with the problem that she cleaned her house obsessively, at all times of the day and night, because she couldn't bear any form of mess. So I gave her some sheets of paper and asked her to tear them up and throw them all over the floor. As she tossed the paper around the room she became increasingly agitated, reproaching herself for the 'mess' she was making. When the paper was scattered everywhere I asked her to walk on it. Although she was very reluctant.....she did....but after a few moments she became distressed and wanted to lie down on the floor. When she felt a bit more comfortable I asked her to lie down on the mess and as she did so she began to cry. I supported her as much as I could....but kept on encouraging her to continue with the exercise.....Finally she came out with: "I'm a bad girl". Well one thing led to another and the cause of her 'badness' surfaced. Her father was killed in an accident when she was two and she blamed herself for this all her life. Also she admitted she'd lived with mess ever since she could remember but had no idea it connected with her self-view and what had happened to her father. Although she'd seen a number of therapists over the years, these connections had not surfaced before. It seemed to me that talking about her messiness didn't allow her to get to the root of the problem..... but when she exaggerated her symptoms it took us to their underlying cause....and the whole issue of messiness faded away.

This excerpt espouses a humanist ethos that honours the client as a source of healing. The plant metaphor infers that individuals have an innate capacity to grow provided they are nurtured and supported. However, it also implies that when clients are deprived of care their capacity to develop is arrested, manifesting as disabling symptoms that impact on personal freedom. This is viewed as a form of "stuckness", associated with personal blocks and a failure to thrive. Thus individuals are hampered by disabling thoughts, feelings, and behaviours. However these symptoms are paradoxical as they embody the roots of curative change.

Essentially, the clinical vignette posits that client symptoms are utilized by skilled therapists to unpack client difficulties so their core ingredients may be addressed. This example proposes that when these elements are exaggerated in a supportive manner, paradoxically, this leads to the resolution of inherent problems that underpin these symptoms. In effect, the vignette demonstrates that client symptomology may be exploited by empathic, strategic therapists to facilitate healing. This inventive approach honours symptoms as markers and signposts that lead to the source of change. Moreover it highlights the creativity and competency of therapists who implement this approach. Furthermore, this approach is prefaced upon the safety and security of the therapeutic environment. These factors are essential as the therapist takes advantage of client vulnerability to effect curative change. Although the expert commentary in this excerpt focuses on the role of symptomology in effective treatment, it infers that the strength of the therapeutic relationship is paramount. Moreover, trust in the therapist and their mode of intervention is a fundamental feature of this approach. In particular, the willingness of clients to engage in a challenging process is evidenced by the detailed steps revealed in the narrative of the extracted vignette. Interestingly, although the expert makes references that imply the healing process is a collaborative effort facilitated by both client and therapist, there is no reference to the quality of their interpersonal relationship and the quality of therapist competency.

Discussion: Paradox of Symptoms, Effective Therapy and Client Change

Both passages cited also affirm existing research and commentary that proclaims psychotherapeutic symptoms are viewed as opportunities for therapeutic healing (Wampold, 2001). These extracts cast therapists in the role of detectives who unravel clues that are used to uncover the cause of client difficulties (Loewenstein, 1992). Moreover, client and therapist form a collaborative partnership that enables both parties to explore strategies that overcome debilitating symptoms and problem behaviours. Accordingly, during this process clients develop awareness of the source of their problems and become more receptive to therapeutic interventions.

Although reduction of symptoms is traditionally associated with curative change, diverse psychotherapeutic paradigms and theories dispute their effects. On the one hand, the modernist, positivistic paradigm regards symptoms as expressions of client pathology. This approach typifies the medical meta-model that views symptoms as manifestations of internal disease (Gross, 1978). Essentially, this perspective adopts objective criteria to respond to symptoms that indicate the presence of disease. In general terms, this approach constructs illness as form of biological dysfunction that is treatable through chemical and associated medical interventions (Elkins, 2007). On the other hand, the contextualist postmodernist paradigm strives to avoid the application of pathological labels to the human condition. This stance views ill-health as a social problem that exists within the broader context of the lives of clients (Wampold, 2001).

Within the context of psychotherapy, the positivistic meta-model consists of five components. Firstly, these posit that clients suffer from disorders, problems, or complaints that manifest as symptoms. Secondly, psychological explanations are thought to account for these symptoms. Thirdly, these explanations are said to present knowledge and theories that take account of mechanisms of change. Fourthly, therapists are encouraged to administer specific therapeutic ingredients that stem from these psychological explanations and mechanisms of change. Fifthly, the benefits of psychotherapy are said to derive from these specific ingredients (Wampold, 2001). Essentially, this approach discounts the relevance of client subjective experience and views symptoms as indicators that clients are ill. Consequently, therapists draw on their skills to bring clients back to health. The extensive use of the medically-exclusive Diagnostic and Statistical Manual of Mental Disorders (DSM) exemplifies this movement.

On the other hand, with the contextualist meta-model offers a more rounded view. This approach, formulated by Frank and Frank (1991), contains four components that require the active involvement of both client and therapist. The first element demands the presence of an emotionally charged, confiding relationship between therapist and client. As this evolves the client increasingly divulges emotional and psychologically

sensitive material to their therapist. As clients come to believe therapists are acting with their interests in mind, this functions as the second component. The third element points to a conceptual scheme or myth that functions as a plausible explanation for client symptoms. Moreover this explanation must be consistent with the worldview of clients. Finally, the active participation of both client and therapist is required in rituals that reflect the rationale of this scheme or myth (Wampold, 2001). Indeed Frank (2006b) posits symptoms are self-corrective healing rituals.

Thus, both excerpts of research material appear to adopt a contextualist stance that views symptoms as rituals within the therapeutic environment that transform problems into healing opportunities. However, in contrast to the passages quoted, this approach by Frank and Frank (1991) does not elaborate on how these healing rituals are enacted. Thus the role of symptoms is examined within the wider context of therapeutic modalities. Specifically the focus of inquiry turns on whether exaggeration of symptoms always exposes the source of client difficulties and induces change. Although this assumption is implicit in the passages presented as research excerpts, it is necessary to examine specific theoretical frameworks that inform divergent approaches to therapy.

Function of Symptoms

A review of the literature suggests a number of therapeutic modalities use client symptoms as therapeutic techniques. Although methods such as paradoxical intention attain first order change (Lyddon, 1990), they illustrate the importance of symptoms in the therapeutic process. Accordingly, these are examined briefly in the context of the findings of this research. The stand-alone therapy of paradoxical intention has the effect of diminishing client fears and compulsions. This approach encourages clients to intensify symptoms to overcome their difficulties. Originated by Frankl (1984), this strategy constitutes a process that encourages clients to practice intensifying habits or thoughts with the aim of removing dysfunctional behaviour. This method is based on the belief that the act of trying to directly control or limit fears or compulsions triggers an anticipatory anxiety that augments these symptoms. Essentially,

by turning fears or compulsions on their head, the anticipatory anxiety that elicits and reinforces client dysfunctional behaviour is diffused.

Furthermore, a number of therapists within the behavioural and family domains such as Haley (1976) and Watzlawick, Beavin & Jackson (1967) incorporate paradoxical strategies into existent therapies. Although these approaches subscribe to the belief that "if a therapist would do it, do the opposite" (Weeks & L'Abate, 1982, p. 4), they do not focus on symptoms as strategies to unpack the root of client problems. In the main, these paradoxical measures aim to reduce the potency and occurrence of specific behavioural patterns. Indeed Wolpe's (1958) behavioural therapy of extinction by massed practice exemplifies this approach.

In comparing these paradoxical therapies with the ideas expressed in the research excerpts detailed above, it is clear that the former fall within the ambit of the medical meta-model. Similarly, these approaches seek to attain first order changes of symptom reduction and behaviour management. In contrast, this overarching theme that links symptom exploration with client change and effective therapy differs significantly from this approach. Essentially, this notion resembles the kinds of internal, second order change envisaged by Lyddon (1990) that is transcendent in its effect. Moreover, these symptoms are not viewed as expressions of pathology but parts of a narrative in the lives of clients that point the way to change. Furthermore, this approach does not smack of the specificity of paradoxical forms of psychotherapy that characterize the positivism of the medical-model. Alternatively, the symptomology, referred to in the passages quoted, indicate that clients develop behavioural adjustments to manage difficulties they encounter. Accordingly, this approach reflects a contextualist position that acknowledges these strategies are constructive adaptations that may be unpacked collaboratively by client and therapist. In contrast to the medical meta-theory, this contextualist view examines the total experience of clients in the framework of their lives. In effect, this quest focuses on unraveling the underlying cause of symptoms whereas the paradoxical psychotherapies centre on the elimination of these behaviours.

In concluding this discussion that links client symptoms with effective therapy and client change, it seems that client behavioural adaptations are constructed as beneficial responses to difficulties in life by this study. Accordingly, these may be ameliorated through the enactment of collaborative healing rituals that seek to identify the cause of this client adaptation. As this is generally beyond client awareness, both client and therapist facilitate this quest through collaborative inquiry. Thus, exaggeration of symptoms may be seen as a strategy to achieve this objective that falls within the contextual paradigm of psychotherapy. As some informants spoke at length of the function of client psychological mindedness in terms of effective psychotherapy, this was identified as a sub-theme of client contribution.

Sub-Theme 2.2: Client Psychological Mindedness

Although many theorists and clinicians contend effective therapy requires the psychological mindedness of clients, the meaning of this construct varies. Thus the nexus between this notion and effective therapy is explored in the excerpts that follow.

Research Excerpts

Client reflections on their experience are important. It means they feel safe enough to reveal themselves....but it's more than that...their insight is valuable...it's part of the shared understanding about how therapy works. I don't think this has to be sophisticated.... although therapy has to make sense to them...so client input and ideas essential.... their awareness is the real source of change.

As a number of experts emphasized client psychological insight and awareness contribute substantially to client capacity to embrace change, this sentiment is reflected in this first passage. Although it does not make direct reference to psychological mindedness, it refers to similar constructs such as client insight, understandings, ideas and awareness. Thus these descriptors are combined in a synthesis that amounts to client psychological mindedness. Moreover the tone of this passage indicates client resources

impact significantly on outcomes. The clinical vignette that follows captures the ingredients of this synthesis.

A client started therapy and right from the beginning she felt we had a strong spiritual connection ...And she said this again and again. One day we were working on some early childhood issues and a strong image of a baby came to both of us. We couldn't actually see it but we both sensed it... so we worked with it for several months. I think we could do this because the client had such a clear understanding of what was going on. She was very aware of how she was feeling and what was happening in the room...and she knew I could contain the process even though I questioned what we were doing many times. When we talked about it... we thought the baby could be a part of her that hadn't developed.... or alternatively, that she was in contact with a new spiritual dimension of herself. Even though it was very unusual work and we struggled with its meaning.... we both felt that it enabled her to become more whole. It opened her up to a massive change. Eventually she left therapy with a renewed zest for life.

The collaborative relationship between client and therapist captured in this vignette acknowledges that the client is intimately involved in the decision-making process. Moreover she displays an advanced understanding of the therapeutic process, awareness of the interpersonal dynamics that inform the progress of therapy, unusual and challenging features of the therapeutic environment, and openness to unexpected and unpredictable events in the shared experience of client and therapist.

Consequently these findings confirm previous research that postulates client psychological mindedness embodies a principal informant of effective psychotherapy is apparent here. Indeed Lambert & Asay (1984) characterize psychological mindedness as an extratherapeutic factor with the capacity to induce change in therapeutic outcome. This construct, together with client traits such as motivation, capacity to trust, intelligence, and resilience fall within the ambit of common factors that influence change. However a review of the literature indicates that definitional notions of psychological mindedness are vague and uncertain.

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Discussion: Meaning of Psychological Mindedness

Surprisingly, although the notion of psychological mindedness has a long history within the mental health domain, it was not identified as a specific concept until the second half of the last century. According to Farber (1985) the history of psychological mindedness dates back to Murray's (1938) concept of 'intraception'. This refers to personal temperament that emphasizes psychological aspects of persons or events. However, further investigation reveals that James' (1991, p. 94) "tender-mindedness" and Jung's (1922) 'introversion' predate Murray's ideas as expressions of psychological mindedness. Nevertheless, despite this lineage, psychological mindedness remains an elusive concept closely associated with insightfulness, reflexivity, self-appraisal, self-awareness, and introspection (Applebaum, 1973).

Although most clinicians recognize the value of psychological mindedness intuitively, empirical legitimacy is negligible. As this is an abstract process that cannot be observed directly, researchers implement complex idioms to enunciate the meaning of psychological mindedness. As this is invariably influenced by specific therapeutic frameworks, operational definitions of psychological mindedness vary considerably despite the presence of similarities.

Various Definitions of Psychological Mindedness

From a historical perspective, individuals who grapple with the notion of psychological mindedness tend to be psychodynamic theorists

within the psychoanalytic therapeutic arena. Indeed, interest in psychological mindedness grew from attempts to identify clients suited to analytically oriented therapies. Accordingly, many of these efforts stem from analytic concepts. For instance, Tolar and Rezinikoff (1960) perceive psychological mindedness as the ability to comprehend causative factors that underlie behaviours and attitudes. They also contend this encompasses an ability to comprehend defense mechanisms and unconscious conflicts. Alternatively, Reiser (1971) argues that psychological mindedness consists of sensitivity to symbolic meaning and patterns in life events, empathy and intuition towards the affective states of others and curiosity about human behaviour. Moreover Lower, Escoll, and Huyster (1972) view psychological mindedness as a complex notion that demonstrates “a capacity for insight, introspection, intuition, remembering dreams and fantasies, awareness of transference, of internal conflict; sensitivity to own feelings and curiosity about drives” (p. 615). Appelbaum (1973) suggests psychological mindedness is a “person’s ability to see relationships among thoughts, feelings, and actions, with the goal of learning the meaning and cause of experience and behaviour” (p. 36). This definition closely mirrors Farber’s (1985) description that depicts psychological mindedness as the capacity to reflect upon the meaning and motivations of one’s own behaviour as well as others.

In operational terms, clients who regard the source of their disturbance as external to the self are judged to be at a low point in terms of their psychological mindedness. In contrast, clients who describe their experience as arising from within the self are considered to possess a high degree of psychological mindedness. Similarly, Rogawski (1982) classifies psychological mindedness as the ability to verbalize internal experiences as the product of one’s own mind and feelings that are not caused by another. Levinson, Sharaf, and Gilbert (1966) describe this disposition as a reflection of intellectual and emotional prowess. Specifically, intellectual aptitude pertains to cognitive understanding of psychological issues whilst emotional competence refers to an individual’s capacity to attune to the inner life of the self and others. This resembles Hall’s (1992) definition that depicts

accurate psychological mindedness as “reflectivity about psychological processes, relationships, and meaning displayed by...interest and ability for such reflectivity across affective and intellectual dimensions” (pp. 139-140). Furthermore, Werman (1979) states psychological mindedness relates to one’s conception of the external world, as well as one’s introspective abilities. According to Werman, individuals with high levels of psychological mindedness believe in the random nature of events and tolerate ambiguity. Wolitzky and Reuben (1974) describe psychological mindedness as the tendency to understand behaviour in psychological terms. Dollinger, Reader, Marnett, and Tyenda (1983) interpret this as “reading between the lines of behaviour . . . looking beyond the surface of overt behaviour for underlying psychological meaning or consistency” (pp. 183-184).

Recently, Grant (2001) broadened the definition of psychological mindedness to be more inclusive of cognitive-behavioural processes. This is conceptualized as a predisposition to engage in acts of affective and intellectual inquiry that identify why and how oneself and others “behave, think, and feel the way that they do” (p. 12). Grant’s model proposes psychological mindedness be assessed by measuring the meta-cognitive processes of self-reflection and insight. This approach honours the premise that psychological mindedness involves affective and intellectual interests, abilities and skills. This evidences a predisposition for reflective inquiry and gradual insight. Grant postulates that as increases in insight augment psychological mindedness, this implies this approach is more malleable to change compared with the static characterizations of psychological mindedness outlined by Appelbaum (1973), Farber (1985), and Wolitzky and Reuben (1985). In discussing this revised approach, Grant notes it has special relevance to cognitive behavioural therapies that depend on self-evaluation of cognition and behaviours. This captures the ideas of Appelbaum who views psychological mindedness as a process of insight that empowers individuals to determine the relationship between thoughts, feelings, and actions. Moreover it reflects Farber’s view, identifying motivation as an aspect of psychological mindedness. This stance also

integrates Hall's (1992) psychological mindedness as an ability to develop understanding of psychological processes.

In concluding this discussion Coltart's (1988) conceptualisation of psychological mindedness is instructive. This incorporates a variety of exhaustive features that include client capacity to provide a psychological history; ability to reveal these details without much prompting; client recognition that this account presents listeners with increasing awareness of how they relate to themselves; the facility to recall memories with appropriate affect; an awareness of the existence of an unconscious mental life; the capacity to step back from their experience and observe it reflectively and, finally, increased acceptance of responsibility and enhanced imaginative capacity.

Sub-Theme 2.3: Client Reflexivity

A third sub-theme that relates to the overarching theme of client contribution encompasses the notion of client reflexivity. The majority of participants endorsed the importance of this process as it encourages clients to reflect and live with awareness and insight. A number of experts stressed they honour clients as active, aware contributors to psychotherapy. Furthermore they emphasized that clients formulate suppositions and inferences that support the process of effective therapy.

Research Excerpts

I've recently re-connected with someone I met thirty years ago. The work we did was good enough for him to make his way through life although it was a struggle.....he had to fight his destructiveness. I think this was implanted in him through some illness in his mother that wasn't picked up. And even though he still carries this, he's aware of it. It's part of his symptomology. He is absolutely huge... something like 135 kilos... but knows he carries this for a reason....he's thought it all out. He was referred to a GP who wanted him to have a gastric bypass...but he said to this doctor "If you touch my weight I'll become a monster, a sexual predator... my weight armours and regulates me...it keeps me together and stops me from unleashing what I am." He was telling me that therapy helped him in his

youth....but it didn't fix him. I think our work elicited an internal critic that gave him a purchase in life to protect the world from his demons.

This first passage illustrates the potential for insight that clients bring to the therapeutic encounter. Although this excerpt infers that client and therapist work collaboratively to effect client change, the thrust of the vignette highlights the interpretative and reflexive competence of the client. Specifically, the quote reveals advanced levels of self-understanding this client brought to the way he lives in the world. In particular his perception demonstrates masterful awareness of self informed by ongoing reflexivity that probably emerged as a consequence of his previous experience of psychotherapy.

I had a client who you could classify as a borderline personality although she was never diagnosed as such. She was in a group I was leading and most of the time...she appeared to be very shy, shunning any form of attention. I also saw her disassociate time and time again... so one day I called her on it. I got her to think about her actions by working her response live in the group. It was one of those intuitive moments when I said to myself I'm going to do this because I think it's right. So I said to her "You went somewhere didn't you?" and she nodded. Then we explored what caused her to disassociate. She tracked her thought processes, revealing her defenses and got a lot of support from the group. I think the experience was really helpful to her. I wanted to make her touchable and I think the group did too. It was important for her to think about what she did and why she did it... and then talk to the group about it because she was so shy. When the group ended I didn't see her again but I think something must have really happened for her.

The second passage reveals the approach of a specific therapist who facilitated the development of client reflexivity within a group environment. Although this vignette evidences positive outcome effects, the excerpt is instructive as it demonstrates strategies adopted by the therapist to induce client reflexivity. Accordingly, the presence of client reflexivity opens the doorway to client change. The study establishes

unequivocally that the capacity of clients to engage in critical reflection contributes significantly to positive outcomes. Within psychotherapy, commentators increasingly describe this attribute as reflexivity (McLeod, 2001). Accordingly, before examining the contribution of this notion to psychotherapeutic success, the meaning of reflexivity requires clarification.

Rennie (2001, p. 83) posits theorists traditionally portray reflexivity as a “turning back on itself”. Lawson (1985) contends this capacity stems from the belief, that in moments of self-awareness, clients step out of an activity to critique their actions (Macmurray, 1957). Likewise, Searle (1983) postulates when clients are engaged in action they are immersed in their own agency. Thus, in these moments they are not self-aware. However, this does not mean their action is unconscious or out of their control. In actual fact, these activities are monitored and guided by intention. Consequently, clients have a strong sense of what they are doing and where they are going. Yet when they cease this flow of energy and turn back to look at their actions, clients become self-aware. Accordingly Rennie (2001) views this duality of agency and self-awareness as an expression of individual reflexivity. Moreover, he postulates that reflexivity draws attention to the flow of energy that moves from agency to self-awareness and then back to agency in a reiterative cycle.

Discussion: Reflexivity and Postmodern Therapies

Both excerpts capture Neimeyer’s (2009) view that most postmodern therapies are committed to the attainment of specific outcome goals that focus on the enhancement of client development. These goals include client reflexivity or self-awareness and the capacity for self-change. These manifest in a variety of ways such as expressions of reflexivity encompassing relational responsiveness and openness to others (Leitner, 1995; Rennie, 1992). Empowerment and a sense of “voice” (Brown, 2000) together with the enactment and social affirmation of a preferred self-narrative are outcomes that are hoped for (Eron & Lund, 1996).

Essentially Neimeyer (2009) stresses postmodern psychotherapy construes change as a consequence of client meaning-making capacities

(Bohart & Tallman, 1999). Although new possibilities are brought forth in the dialogic client therapist relationship, client activity and insight ultimately produce lasting life adaptations. Thus this view postulates therapist interventions only have an instigating role in regard to curative factors. In short, therapists merely serve to highlight client resources, adaptive and maladaptive meaning making processes and modes of relating that may have lost their usefulness. Thus client reflexivity is privileged by such therapists who try to identify problematic constructions generally rooted in the formative experience of clients. However the crucial feature, present in both narratives quoted above, turns on the issue of client interpretation. Essentially, postmodern psychotherapy focuses on patterns of meaning interpreted by clients, rather than therapists, derived from client experience through the process of reflexivity. This reflexive process triggers insight and possible behaviour change. Therapists working with this understanding avoid highly interpretative interactions with clients and concentrate on experiential interventions that assist clients in encountering those circumstances that contribute to the adoption of self-limiting patterns that have been perpetuated in current situations. As Neimeyer suggests this reflexive course of action helps client “become connoisseurs of their experience” (p.84). Thus they are better positioned to detach from existent negative self-narratives and forge new, empowering constructions. Although this stance has wide acceptance within humanist circles, Neimeyer’s views appear to marginalize the role of therapist reflexivity. Specifically, relational psychotherapists who practice from a diverse range of therapeutic orientations interpret reflexivity in a relational context.

Relational Turn in Reflexivity

This approach demands that the therapist looks within themselves, at the client, and at the relationship between them. Thus an outward and inward thrust of awareness flows from the self, to the other and to the relationship in a generative, iterative movement. Accordingly, this relational perspective means the therapist stays connected with themselves whilst connecting simultaneously with the client and conceptualizing therapeutic work. Hence, instead of effecting linear and unidirectional

shifts, reflexivity generates a circular loop that moves between these three points. Thus this sustains a critique that manifests constant changes in perspective described as “uncertain of certainties” (Kuenzli, 2006, p. 17). Accordingly, this perpetual back and forth movement between positions enables therapists to continually change perspectives that alert them to the significance of subjectivity.

Moreover, relational postmodern psychotherapists posit the core of reflexivity turns on an ‘as if’ position that attempts to understand clients in the context of their lives. Essentially, this approach argues therapists adopt a specific posture to imagine client experience gleaned from their words, actions and affect expressed in therapy sessions. Consequently, the therapist’s ability to put themselves in their client’s shoes using this ‘as if’ posture is critical. This approach is not a tool or an intervention but an ethic, guided by the intent to understand the other within the context of their setting. Thus Rennie (2006) asserts to insist that clients derive their own interpretations within therapy fails to recognize the interpersonal features of the therapeutic encounter. Once this thrust is taken into account, it authenticates and validates therapist agency. Although client self-sufficiency in resolving difficulties is prized by most postmodern therapeutic modalities, Rennie argues it is legitimate for therapists to bring their interpretation to the therapeutic enterprise when clients are at a loss provided their timing is appropriate. Consequently, as both passages quoted above focus on client reflexivity, they imply that therapist reflexivity is a determinant of effective psychotherapy. Accordingly, this issue is discussed later in this chapter when the common factors that therapists bring to psychotherapy are discussed.

Before completing this critique, it is necessary to point out that although client reflexivity usually occurs during or immediately after an act of client agency, this is not always the case (McLeod, 2001). Although the second passage evidences this general rule, this does not mean that reflexivity cannot occur on an ongoing basis as is the case in the first scenario detailed above. Indeed, as the literature describing the mastery of expert therapists suggests, reflexivity is prized as an esteemed attribute in

constant process of development. Thus it is assumed this dynamic is equally applicable to clients.

Sub-Theme 2.4: Client Openness to Change

The findings of the study identify a fourth sub-theme associated with the overarching theme of client contributions to effective therapy. The majority of participants made the point that when clients demonstrate some sort of openness to change this indicates the presence of effective therapy.

Research Excerpts

Over time clients internalize this benevolent observer to the point that they take on a more humane view of themselves. But it doesn't happen unless they're ready... They need to be receptive... In the beginning, this takes place beyond their range of awareness.... they don't always know they're ready.... but when they do... their openness expands and gradually takes on a life of its own. When I think about I there's this moment in therapy when the person takes a risk.... consciously or otherwise... and refuses to resort to their normal defensive strategies. They let themselves be seen in a much less protected way and a slowly a new sense of self emerges.

This first passage stresses that when clients adopt a more compassionate and accepting self-view, this indicates the emergence of an internal openness that evolves through the beneficial impact of psychotherapy. This openness to the self is echoed in the client's receptivity and readiness for change evidenced in the second excerpt.

This second clinical vignette captures the transformational effect of psychotherapy when clients are accessible, available participants in this collaborative process.

I am thinking of a professional woman who came to see me a few years ago. She was a very intelligent person who was at the point of recognizing there were many issues in her life she needed to resolve. She didn't know what they were and or how to work with thembut she came to

therapy ready to engage with them. I saw her over an eighteen month period.....In the beginning she was chronically depressed, had low self-esteem, an eating disorder, experienced feelings of unworthiness in her work and difficulty in personal relationships..... At first she came twice a week for three months.... During this time she did some very important work around her relationship with her internalized mother as well as her real mother. Although she experienced moments of vulnerability, her availability enabled her to establish boundaries for the first time in her life. In the transference she viewed me as a concerned male who cared about her. This made it possible for her to look at some of her assumptions about herself as a woman and, what lay behind the eating disorder.....Overall she made relatively rapid progress and I think this was influenced by a number of factors. Firstly she felt I was empathically attuned to her experience. I was not frightened of her depression and was able to sit with it week after week..... Secondly I was confident she could and would work through her depression and low sense of self.....Thirdly, and most significantly.....she made a commitment to deal with her issues.....And, certainly....by the time she finished therapy she had a deeper sense of her own entitlement and was more satisfied with her professional and personal relationships.

This notion of client openness to change is referred to in a variety of ways beyond and within the discipline of psychotherapy. Based on the views of the French philosopher Marcel (1971) early nursing literature (Black, 1967) reflects on the need for patients to display availability as a paramount aspect of the healing process. Indeed Colazzi (1975) expands this quality of accessibility by stating that any therapeutic “encounter is the experience of mutual openness of one toward the other” (p.200). Within psychotherapeutic discourse, Rogers’ (1961) client centred therapy is the most obvious exponent of this ethos. This therapeutic modality postulates that all individuals aim to fulfill their potential. Hence, a growing openness to experience characterizes the fully functioning person. Essentially, Rogers claims that as individuals develop, they move away from defensiveness and the need for subception. The latter occurs when individuals unconsciously

perceive a threatening object or situation that creates some form of inner conflict. Accordingly, even though they implement strategies to prevent this threat from entering their consciousness, they often manifest visceral symptoms such as rapid respiration and increased heart rate that indicate their discomfort (McCleary & Lazarus, 1949).

Discussion: Client Openness, Receptivity and Readiness for Change

This phase of the research determined that client openness to change is an informant of effective psychotherapy. Although this stance conflicts with the medical model that depicts clients as suffering from illness and disease, most experts who participated in this study view clients as individuals whose agency is temporarily interrupted by the vicissitudes of life. In contrast to the medical model, this position constructs clients as actors who co-author their life scripts and co-direct their actions by following their own path to solutions (Shulman & Watts, 1997; Watts, 2003;).

Whilst it is suggested that the medical model continues to dominate the field due to its ties with medicine, science, and the health insurance industry (Elkins, 2007) contextualist relational, client centred, and analytic interests oppose this thrust. For instance, a humanist stance espoused by Bohart and Tallman (1996) asserts that all therapy is “ultimately self-help and that it is the client who is the therapist” (p. 9). Even the renowned pan theoretical researchers, Bergin and Garfield (1994), contend the crucial informants of effective psychotherapy turn on the presence of client openness to change. Indeed, for more than three decades these reviewers have recommended that “rather than argue over whether or not ‘therapy works’ we could address ourselves to the problem of whether or not the client works” (p. 825). Nevertheless, despite this focus on client factors, investigation of the influences that reveal how “the client works” rarely occur.

In attempting to explain this position, Barkham (1990) identifies the existence of a considerable gap between the praxis of psychotherapy and relevant research. Greenberg (1986) postulates this stems from the limitations of researchers who choose to study familiar phenomena based on

well-known research designs. Likewise, Gordon (2000) highlights this investigative failure, condemning the reluctance of researchers to grapple with methodological challenges. Citing an early study by Rosenthal and Frank (1958) that compares client characteristics with outcome effects, Gordon (2000) posits this design represents the current blueprint that measures client attributes against selected factors. Specifically, this approach measures social class, gender, personality traits, and intelligence against variables such as therapeutic outcome, continuation in therapy and in-therapy behaviour. However, the link between client action, therapeutic processes, and outcome effects is omitted. Thus, Garfield and Bergin (1986) cite difficulties in measuring devices, 'brand' wars, sampling procedures, and outcome criteria as impediments that interfere with efforts to resolve how clients impact on outcome effects. Moreover they state that

Although the personal qualities and expectations of the client appear to be of importance to most therapists, the more exact description of these qualities in the relationship to outcome in psychotherapy still await more definite research (p. 246).

Although this study affirms previous research that views the client as a common factor informing effective therapy, the issue of client openness to change requires further elaboration. Accordingly, this subject raises the question as to what is meant by client openness.

Meaning of Client Openness

Client openness within this context implies some form of responsiveness moves from the client towards the therapist who facilitates an energetic flow. Although the passages quoted from the study reveal a glimpse of this reciprocal dynamic, the effectiveness of therapy depends on the recursive nature of this response. Although this viewpoint derives from client centred counselling, a number of pan theoretical researchers and commentators expand the notion of client openness to apply to all second-order change modalities. Bohart and Tallman (1999) portray clients as active self-healers who "make therapy work" (p.4). This approach claims that client self-healing capacities and resources are responsible for the

resolution of client problems and change within the context of psychotherapy. This stems from the understanding that clients possess innate capacities for learning and creative problem-solving (Bohart & Byock, 2005). Moreover these problems are viewed as creative adjustments to perceived difficulties they confront in their life. However when clients are blocked by fear, helplessness and guilt from resolving these problems, therapy can empower clients to reconnect with their self-healing, creative resources (Cantor, 2003; Duncan, Hubble, & Miller, 1997; Staudinger & Baltes, 1996; Tallman, Robinson, Kay, Harvey, & Bohart, 1994). Even when clients demonstrate dysfunctional behaviour and resistance, they still have access to these proactive self-healing elements. Thus clients have the capacity to generate solutions to their problems by actively contributing to the therapy process based on their creative understanding of what is appropriate. In effect, they are active, playful agents who extract their own meanings from therapy.

Accordingly a series of researchers indicate how clients enact their openness. Rennie (2002) and Levitt and Rennie (2004) assert clients interpret and construct their own interventions from what they're offered in therapy by using this environment as a "workspace" in which they can talk out their problems and gain perspective. Thus client active involvement is crucial as interventions do not affect clients without their active participation in the process (Elliott, 1979; Elliott, 1984). Hence, enabling clients to feel safe enough to be therapeutically open and involved, so they find their own reasons for changing is paramount. Enabling them to be curious, risk-taking, and exploratory also facilitates this process (Bohart & Byock, 2005).

Client openness within the context of this study also points to client receptivity and readiness as forms of internal accessibility necessary to usher in change.. Although these concepts may have similar general meanings, they are distinguishable within the context of psychotherapy. Consequently each of these notions is examined in the light of research, informed commentary, and the findings of this phase of this study.

Distinguishing Receptivity and Readiness

A number of experts in the study stated they considered client receptivity and readiness for change as vital ingredients of effective therapy. Descriptors such as client availability, and accessibility were associated with client openness by these informants who stressed the role of clients and their willingness to embrace change was often omitted from psychotherapeutic discourse. Moreover, at least two experts stressed that client receptivity and readiness for change were the most important predictors of therapeutic change, regardless of what modality was employed by therapist. Accordingly, these notions are investigated in the commentary that follows.

Phrases used by expert participants in this study describe client receptivity as a precursor to therapeutic change. Typical examples included “I get this sense they know I’m there for them so they can drop their facade and.... really show themselves to me” and “we smiled at each other through our eyes.... and in that moment our hearts opened to receive the other”. Thus receptivity implies some sort of mutual exchange between client and therapist. Accordingly, it embodies an experience explored by relational, experiential, and analytic psychotherapies as a component of effective therapy. Accordingly discussion of these viewpoints constitutes the next task of this commentary.

From a person centred approach, Geller and Greenberg (2002) describe receptivity as a kinesthetic, sensual, physical, emotional, and mental experience that is fully taken into one’s being in a palpable and bodily way. This response demands a conscious intention to remain open, allowing, and accepting to all of the dimensions of the experience. The allowing quality of receptivity embodies a distinct process of letting in experience and allowing it to flow through oneself. The experience of this phenomenon contrasts with the observer role that witnesses experience from an emotional or clinical distance (p. 78). Moreover these somatic explanations share commonalities with Cartwright’s (1998) analytic stance that posits clients are required to change their receptive capacity to recognize, think about, and eventually re-internalize disowned parts of the

self. Carnegie contends this effect may arise when therapists facilitate mutative moments (Carpy, 1989) that lead to changes in the receptive capacity of clients through the quality of relational connection between client and therapist. Alternatively a relational view espoused by Cooper (2008) suggests that receptivity refers to the ability to allow what happens in a situation to matter to oneself. Essentially, this means to 'take in' or receive the world so that one is accessible and available to the other. In these moments, clients attempt to communicate something that sits at the very core of their being. Cooper (2005) describes these experiences as substantial, deeply meaningful and significant encounters that have a curative effect on clients. Moreover these moments are generally associated with considerable vulnerability as clients seem to connect to these events to heightened affect.

Although readiness for change is an attribute of cognitive behavioural therapies that privilege motivational interviewing as a key determinant of client change, most of the statements made by experts in this study adopt insight oriented approaches to describe this notion. Typical phrases used to describe client readiness for change included "I realized she'd reached the bottom of the barrel"; "they'd reached the end of their tether" and "the only way left to them was up". Moreover participants acknowledged that clients frequently expressed shame and guilt as a precursor to their selection of more productive behaviours and attitudes. Other factors indicating client readiness for change includes the recognition that avoidance would not resolve their difficulties. However expert participants cited sudden, observable moments as the most striking indicators of this willingness to embrace change. Nonetheless others stated that although these changes were clearly identifiable, they could be unpacked over the course of therapy as slow and gradual shifts over time. Thus, in keeping with qualitative studies undertaken by Greenberg(1994)McLeod, (2001) Clark, Rees, and Hardy (2004), and Klein and Elliott (2006) the findings of this study contend client readiness is paradoxical in that individuals experience change in a simultaneous thrust that is both sudden and slow.

Summary of Theme 2: Client Contribution to Change

In summarizing the second overarching theme of this second research phase, it is evident expert therapists consider clients contribute substantially to making therapy work. Indeed this determination reveals clients are 'active ingredients' in the change process. However this view conflicts with the medical model that espouses therapists and specific modalities are the primary determinants of effective therapy (Bohart & Tallman, 1999). In contrast this study determines that practitioners consider clients bring a strong, proactive healing dynamic to the therapeutic encounter, regardless of the degree of their difficulties. Indeed this study demonstrates clients present symptoms or problems in therapy when their self-healing creative capacities are temporarily blocked. Consequently, these difficulties are healing opportunities that open the doorway to change. In this context the psychological mindedness of clients and their reflexivity are viewed as determinants of therapeutic change. Although these influences are reported in the literature their nexus with effective psychotherapy is rarely stressed in previous research. Finally, client openness to change together with implicit notions such as reflexivity and readiness for change are cited by this study as strong influences on therapeutic success.

Whilst a body of research determines client contribution to effective psychotherapy amounts to forty per cent of outcome effects (Asay & Lambert, 1999; Bergin & Lambert, 1994; Lambert & Barley, 2001), many of these investigations are reflective of positivist empirical research (Gordon, 2000). Although most of these quantitative inquiries recognize factors identified by this study do impact on change and effectiveness, they rarely explore these notions in terms of the human understandings that underpin these findings (Maione & Chenail, 1999).

In addition, although this West Australian study affirms prior rationalist studies, it underscores and expands details of client features that are often minimized within the context of the outcome literature. Notions such as client receptivity, readiness for change, and openness to change as well as psychological mindedness are rarely investigated by empirical

research although they are reviewed by constructive approaches (Cooper, 2008; Mearns & Cooper, 2005). Moreover, although client centred therapies, humanist, and relational approaches engage with these ideas, with some exceptions, their investigations are cursory in the context of effective therapy (Geller & Greenberg, 2002). Indeed this is somewhat paradoxical in view of the call for action espoused by Duncan, Miller and Sparks (2004) on the front flap of their book *The Heroic Client* more than a decade ago:

Psychotherapy has for too long relegated the client to a minor role in the drama of client healing. Moreover in today's system of managed care, the client is marginalized further as the field is increasingly medicalized and supervised by only those interested in the bottom line. The result: clients are depersonalized by diagnostic labels that have predetermined limits to care, leaving them with few options for meaningful, individual treatment. And this system often forces therapists of all disciplines to forgo new or alternative treatments, leaving them enslaved to follow practices in which they no longer believe. It's time for a radical change.

Overarching Theme 3: Contribution of Therapists

The study establishes that therapists contribute substantially to effective psychotherapy. The significance of this finding is noteworthy in view of the recent assertion by Duncan, Miller, Wampold, & Hubble, (2010) that research into therapist factors represents “the next frontier” (p. 424) of outcome research. Indeed they make the point that it is most unfortunate “that little effort has been expended on studying the characteristics or actions of effective therapists” (p. 425). In particular, Duncan et al. point to studies by Ricks (1974) that establish the behaviour of disturbed adolescents is significantly improved by the involvement of ‘super-shrinks’. Accordingly, Miller et al., bemoan the fact that this approach that examines the impact of highly skilled therapists is not taken up more commonly in the domain of outcome research. They assert that new initiatives in the form of practice-based research are required to examine the role of therapists based on client feedback within real-life clinical contexts. Significantly, they postulate this exemplifies a ‘new

frontier' of research that is badly needed within the realm of outcome research. In particular, they claim this kind of inquiry pushes the research field beyond the limits imposed by randomized controlled trials. Instead of repeatedly testing the efficacy of specific modalities, this approach turns attention to moment-by-moment realities of process developments that characterize the therapeutic environment. As much of this is likely to investigate the actions and attitudes of therapists, the relevance of this qualitative study that explores these concepts from the stance of expert therapists is timely and relevant.

Consequently, this inquiry ascertains expert therapists consider therapist input to be a crucial determinant of client change and effective psychotherapy. Nevertheless, although this assertion is espoused by numerous researchers (Beutler, Machado, & Neufeldt, 1994; Lambert, 1989; Lambert & Okiishi, 1997; Luborsky et al. 1986; Norcross, 2002, & Schacht, 1991), knowledge of the impact of psychotherapist effects requires further elaboration. Thus the second phase of this inquiry identifies a number of therapist qualities that enhance effectiveness. These are viewed as sub-themes of the overarching theme of therapist contribution and include the commitment to search for emotional truth; therapist authenticity, presence and receptivity; maintenance of a participant-observer stance and acumen. Accordingly, each of these sub-themes is examined as the next task of this review.

Sub-Theme 3.1: Therapist Commitment to Emotional Truth

The sub-theme of therapist emotional truth is acknowledged as a determinant of effective psychotherapy and client change. Although the meaning of this notion is ambiguous a number of informants postulated therapist commitment to emotional truth has a substantive impact on therapeutic success. The excerpts that follow demonstrate the significance of this influence.

Research Excerpts

You make a commitment to seek the emotional truth...and even though ultimately truth is unknowable.....you make the commitment because truth is the most important in therapy....It demands certain courage and humility and a real respect for human frailty as well as the recognition that people are doing the best they can. And sometimes you have to speak the unspeakable. You have to face up to what's really happening between you and the patient and name it and it's often very confronting because we all fear being emotionally naked.

Although half of the study's informants cite the commitment to seek emotional truth as an objective of effective therapy, they allude to this with intense dedication. Indeed the obligation "to seek and speak the truth" is named by one informant as the key ingredient of effective therapy. This focus is reflected in the first passage that privileges therapist courage, humility and respect for the frailty of the human condition.

It's such a difficult thing to define. Words like 'emotionally what is'.....Bion talks about it as 'the hatred of reality that exists in most people'. It's about being able to face reality. And then again, what is reality? It's not an objective reality... it's the reality of one's experience....As therapists we have to be very courageous in seeking emotional truth.

The participant then refers to a clinical case that illustrates this concept:

An example comes to mindsome years ago I worked with pedophiles for a certain time...and it evoked all kinds of disturbing feelings in me....It was difficult work....I had to understand where these people were coming from. I had to know their history and what led to their terrible, terrible struggle. But at the same time I knew I was grappling with my own repugnance...So I had to make a clear distinction in my mind between respect for their battle with overwhelming compulsions and my disgust at their behaviour. And as I worked I realized I had to relate something of my dilemma to them I couldn't be wishy washy about it....owning my reactions was necessary.

Although the meaning of emotional truth lacks clarity within the context of psychotherapy, a number of theorists attempt to illuminate its meaning. Perhaps Bion's (1963) efforts to enunciate relevant definitional understandings are most notable. Essentially, he describes this quest "as the need for an awareness of an emotional experience" contending that "the mind lives on psychic truth as humans live on food. Thus this deprivation of truth has a detrimental effect analogous to physical starvation (p. 56)" that ends in emotional depletion, stunted psychological growth and illness. Schneider (2005) enhances Bion's (1963) contention by affirming that the drive to know the truth of one's emotional experience represents a vital need as essential as water, food or sex. This stance posits that individuals who live without emotional truth experience life as meaningless. Yet, paradoxically, Bion contends this drive is accompanied by an oppositional drive to safeguard of the self from the discomfort of truth. Consequently, tensions between this need to know and desire not to know play a pivotal role in the dialectic of relational movement within psychotherapy. In addition, Bion expands on the polarity of these oppositional forces by stating clients choose to deny or affirm reality, misrepresent or disclose experience, or communicate or repress thoughts and feelings. Nevertheless, despite these paradoxical urges or because of them, Bion (1977) asserts that the commitment to emotional truth embodies the most significant contribution of psychotherapy.

Discussion: What is Emotional Truth?

Although a substantive number of experts in this phase of the research assert the quest for emotional truth is a key informant of effective therapy, it is significant that the majority of these informants view themselves as analytic psychotherapists. Specifically, they describe themselves as "Kleinians", "intersubjective clinicians", or following "the middle school of British object relations". As emotional truth is well-described in the psychoanalytic literature, this study adds little to these understandings other than the recognition that this notion may be increasingly viewed as a determinant of best practice. Although the analytic literature examines the meaning and operation of this construct, it does not

overtly link effective psychotherapy with the therapist's search for emotional truth. Thus in view of the strength of this thematic finding, the next task of this review examines the meaning of emotional truth within the context of informed discourse.

Analytic Interpretations

Essentially, Bion (1965) posits the commitment made by psychotherapists to contain the emotional experience of a therapeutic encounter involves a complex process of thinking and feeling. This is instigated by therapists endeavouring 'to know and understand' phenomena that manifest within the intrapsychic and interpersonal world of clients. In commenting on this function, Bion makes the point that knowledge of this kind turns on the striving of psychotherapists to make the unknowable known. Yet, paradoxically, Bion qualifies this stance by stating that one "cannot ever really know an experience because an experience, itself, is unknowable... all one can do is attempt to become" p.148). Essentially, this position submits knowing about reality is different from being reality; knowing about life is different from being in life. In effect, Lapinski (2006) asserts Bion's search for emotional truth is not a quest to resolve problems but rather, it strives to bring client ignorance of an emotional experience into awareness in the way that light illuminates darkness. To achieve this objective, Symington and Symington (1996) posit that Bion (1966) adopts two principles: "the emergence of truth and mental growth" (pp. 2-3). Specifically, they underscore Bion's belief that the mind grows through exposure to truth during the process of emotional experiencing. Thus the evolution of emotional experience into the capacity for thought and the derailment of this process are the primary phenomena of this model. Essentially, knowledge of the client's emotional life leads to client growth in thought attained by the process of learning from experience. Thus, this 'need for awareness of an emotional experience' becomes the central issue in the search for truth within the context of therapy. In effect, the therapist brings this state of privileging emotional experiencing to the therapeutic encounter in the search for truth within the phenomenological experience of the client. Consequently, this search for truth challenges

clients to “survive the loss of protective coat of lies, subterfuge, evasion and hallucination... in the process of emotional experiencing” (Bion, p. 128).

Although the majority of experts explore the notion of emotional truth in analytic terms, two informants discuss this notion in the context of client symptoms. Statements such as: “You have to look behind the symptom and see what’s going on” and “as the symptom is just the tip of the iceberg, you use the symptom and intensify it to get at its real purpose” exemplify their response. Thus whilst the search for emotional truth is primarily an analytic construct developed by Bion (1966), it is adopted by a number of experiential psychotherapies. For instance, Ecker and Hulley (1996) developed coherence therapy from a program of sustained research into the significance of client symptomology. This approach postulates that seemingly irrational client symptoms are actually orderly expressions of personal constructs rather than signs of pathology. This therapy aims to bring clients into a direct state of symptom-experiencing to facilitate discovery of the unconscious processes that inform symptomology. Accordingly as therapists look for this emotional truth, clients are thought to gain conscious awareness of these forces. Consequently this awareness eventually results in symptom dissolution. The next task of this discussion examines the sub-theme of therapist authenticity as an informant of effective psychotherapy.

Sub-Theme 3.2: Therapist Authenticity

This study ascertains that therapist authenticity and effective psychotherapy are interconnected constructs even though this trait evades explicit meaning. While most theorists and researchers applaud the necessity for authenticity, the meaning of this construct is ambiguous and prone to highly variable interpretations. The research excerpts that follow highlight this inconsistency.

Research Excerpts

In the sixties Rogers came up with empathy, congruence and warmth to capture what’s needed in therapy... and I think he was pretty spot on. But his ideas have become so hackneyed that it’s difficult get a handle on what

he meant. I think he was talking about how real therapists must be ...how genuine they are...And naturally this depends on how they have dealt with their stuff...I mean... how much personal work they've done and how this shows up in their work. I'm sure I don't have to tell you that....the more they work on themselves...the more real they become as people... and as therapists...and even the most unconscious patients can pick this.

This first passage equates therapist realness and genuineness with aspects of Rogers' (1957) core conditions as a key influence on effectiveness whilst the clinical vignette that follows centers on a therapeutic error that arose from the lack of authenticity on behalf of the therapist.

I was working with a young woman ... whose early life history exposed her to the experience of a mother who was very preoccupied with her professional work. My client was placed in day care from an early age because her parent's marriage failed and her mother had to work. And as my client grew older she had the sense and belief that her mother was always at work....She actually felt that work was more important to her mother than she was.....And at one stage....during therapy.....when she was particularly vulnerable.... I was due to travel overseas for a conference.....I became very concerned about her....and I invited her to telephone me whilst I was away...So she did ...but when she called at the arranged time I was preoccupied with the conference ... I was also very tired and not really present at the phone call.... I certainly wasn't engaged with her as I should have been... It was a real mistake! In fact it would have been better to tell her before I left that I would not be available for the whole month I was away....It would have been more real....By the time I came back she was depressed and psychotic. Eventually she stabilized and we began working together again....After some time she admitted she'd been enraged by our phone call....she was really aware that my mind was elsewhere....and this brought up feelings of worthlessness and despair....not only was she not enough for her

mother.....she was not enough for me! It took a long time.... but finally I regained her trust ...but it took more than a year!

Although the therapist in the clinical vignette cited above restores the integrity of the working alliance, this damage caused by this mistake took a great deal of time and effort to redress. Thus when practitioners are inauthentic, their actions place the therapeutic relationship in peril. Nevertheless, despite the importance of this notion, its meaning has occupied the minds of researchers from the earliest conceptions of Rogers' (1961) core conditions. Accordingly a cursory overview of literature and its attempts to define therapist authenticity are presented as the next task of this review.

Discussion: Variant Meanings for Authenticity

The need for therapist authenticity is commonly misrepresented as a license to express practitioner feelings and needs in an undisciplined manner within the psychotherapy hour (Lietaer, 1993). Alternatively, therapist authenticity is used to condone the praxis of revealing negative countertransference. This refers to the redirection of a therapist's feelings towards clients, or more generally, the therapist's emotional entanglement with clients. During the 1960's being authentic meant self-disclosure in a way that was confronting and challenging to clients. Thus unbridled therapist openness in terms of self-disclosure came to be viewed as destructive (Greenberg & Geller, 2001).

Over time the notion of authenticity was defined by humanist therapies as the experience of therapist congruence. This concept is divided into two distinct parts: the ability of the therapist to be aware of their internal experience and the willingness to communicate this to the client in the therapeutic dyad. Indeed Rogers (1961) refers to the notion of 'being real' that emphasizes both these dimensions. Thus, by being congruent the therapist becomes aware of their internal experience and is also willing to share it with clients. Greenberg and Geller (2001) make the point that within client centred therapies, congruence clearly possesses two components: an internal part in which one is aware of one's internal flow of

experience and an outer component that refers to explicit communication. However, over time, the latter component is consistently confused with therapist openness and honesty, resulting in controversial interpretations in meaning. Although there are numerous attempts to counter this uncertainty, generally speaking pan theoretical commentators tend to shape and mould constructs such as realness and authenticity that incorporate the dual components of congruence to move away from its loaded nomenclature.

In considering the meaning of authenticity Miller and Stiver (1997) define it as attempts “to be with” the thoughts and feelings of clients within the therapeutic relationship. As Miller and Stiver also posit therapists are responsive to client needs for relational connection, they proclaim authenticity means therapists are fully engaged in the moment-to-moment interactions within the therapeutic environment. This includes sharing their own experience with clients as well as questioning them about their experiences. Jourdan, Walker, and Hartling (2004) contend therapist authenticity brings a quality of presence to the therapeutic relationship that acts as a substantive resource for client growth. In particular, when therapists are authentic they convey important information to clients about their impact on others. Accordingly, clients learn that authenticity influences the cognition and affect of others. This growth in relational awareness assists clients in contributing to the authentic flow of human interaction. However, Miller, Jordan, Stiver, Walker, Surrey, & Eldridge (1999) make the point relational authenticity does not mean therapists use therapy to meet their own needs. Essentially, they interpret therapist authenticity to mean the therapist is present, responsive, and real. Accordingly their actions are based on the context of each relationship and on the knowledge of complex factors that foster the growth of an empowering relationship.

Authenticity and Relational Awareness

This thematic finding confirms existing empirical research and informed commentary that therapist authenticity is an influential contributor of effective psychotherapy. In common usage Starr (2008)

conceptualizes this notion as a generalized state of being that demonstrates congruency in ideals, values, and actions towards self and others. Within the realm of psychotherapy early commentators such as Kaslow, Cooper, and Linsenberg (1979) describe therapist authenticity as honesty, openness, realness, and sincerity. Moreover this discourse stresses that when therapists model these attributes, they provide clients with opportunities to learn constructive behaviours they may have not experienced previously. Furthermore this theme also emerges in early psychoanalytic developments when Alexander (1961) developed the notion of the corrective emotional experience. This intervention moves from the authenticity of therapists who seek to repair past traumas that clients are unable to confront. Accordingly, this approach facilitates the development of client internal growth.

However, with the emergence of the humanist-person centred therapies (Bozarth, 1998; Rogers, 1961) and the relational turn in psychotherapy (Renolds, 2007) therapist authenticity takes on much more of an interpersonal thrust. Indeed both approaches assert that when therapists are authentic, this implies they are present and deeply moved by their encounters with clients. Specifically, as therapists practicing from both these stances share their experience with clients these disclosures have a powerful reciprocal effect on them. Essentially, clients become intensely affected as they become aware their therapist feels for and with them. Moreover, as this experience provides clients with the opportunity to recognize their thoughts and feelings have an impact on others, the experience becomes a mutual, shared encounter. Although therapists may be hesitant to admit they are moved by client experience, authentic therapists reveal their response, aware this may have a curative effect. Specifically, this kind of therapist transparency gives clients a sense of being 'known' that is profoundly healing. As clients respond positively to authentic therapists whom they view as flexible and non-defensive, it is beneficial to establish why practitioner authenticity is so important. Miller and Stiver (1997) espouse a relational-cultural perspective that suggests authentic therapists use their emotions and their experience as instruments to facilitate therapeutic movement (Jordan, Kaplan, Miller, Stiver & Surrey,

1991). To achieve movement in relationship, Miller, Jordan, Stiver, Walker, Surrey & Eldridge (1999) suggest therapists are aware of “strategies of disconnection that arise out of disconnecting experience” (p. 2). Although these relational therapists espouse the desire to connect with others is a shared human value, they also assert that when individuals encounter hurt and humiliation, a part of their interiority disconnects from others. Accordingly, conflict arises in individuals as they engage in an internal ‘dance’ of connection and disconnection. Miller and Stiver name this inconsistency the central relational paradox whilst methods that individuals implement to maintain this paradox are coined strategies of connection and disconnection.

Relational therapists argue that when authentic therapists honour the central relational paradox this facilitates relational movement. As they are conscious of client internal conflict, they flow with this duality that seeks connection, yet employ strategies of disconnection. Accordingly, therapists engage in authentic moment-to-moment responsive interplay in which therapists convey how they think and feel to clients. This enables both parties to move towards mutuality and trust that enhances relational connection. Rustin (1970) captures this shifting dynamic by citing Kopp’s (1969) example of an authentic relationship between a Jewish spiritual leader, a ‘tzaddik’ and his young protégé. In linking this with the therapeutic relationship, Raskin stresses the protégé sought the tzaddik for the purpose of relational intimacy as well as knowledge:

Perhaps the tzaddik teaches the therapist most of all... that we fail... if we set out as technical experts...from a position of detachment, to help the patient. Instead, we must simply be willing to be with the patient, to get to know him and let him know us. We must trust our feelings over our knowledge and live out truth rather than perceive it. We must risk the possibility we will become personally vulnerable to the patient and he will become truly important in our lives (p. 49).

Hence this research concludes therapist authenticity constitutes a determinant of effective psychotherapy. Although this finding adds little to

current knowledge regarding the meaning and effect of this construct, it does emphasize this therapist quality is a significant contributor of client identity change.

Sub-Theme 3.3: Therapist Presence

A third sub-theme associated with therapist contributions to effective therapy was identified as practitioner presence. Indeed Buber (1937) insists for a genuine meeting to take place, therapists must be present as human beings and endeavour to meet clients from the depths of their being. Presence necessitates therapists bring the fullness of themselves to their interactions with clients and be willing to be touched and moved by them. Moreover therapists are present when they do not try to influence clients to see them according to their own self image (Jacobs, 1991).

Research Excerpts

It means I'm in some kind of altered state...like an expanded state of consciousness. I get the sense that I merge with the client so our boundaries become quite diffuse... it's a liminal state that feels sacred and spacious. I become aware of a quieting down and a more reflective intimacy... I feel centred and grounded...like there's no one else around. So we enter this space and it's really spacious and powerful and there is this recognition that we are separate yet joined. This spaciousness goes beyond the room...I feel myself plug into a much bigger space that feels full and empty at the same time.

The first extract highlights the liminal aspects of presence as depicted by the use of phrases such as “boundaries become quite diffuse” and “we enter this space and it’s really spacious and powerful”. In contrast, the second passage that follows is far more focused on listening to clients and oneself in the therapist role.

Therapy is about how you, as a therapist are present and available to clients. Presence is about how you, as the therapist, immerse yourself in their experience. It's about how you listen...become curious and

respectful...and open up to the patient's phenomenology. It's about listening completely and fully to the client, listening to your own wisdom and allowing both these things to lead a conversation that has the potential to be curative. And it's important to realise this kind of listening is different to auditory listening. When you're present you become more conscious of the toning, the colouring and the nuances of client responses... as well as your own.

Although the first excerpt reflects spiritual aspects of presence, the second is much more grounded in the here and now in the physicality of the therapeutic environment. Thus the study establishes expert West Australian therapists consider the quality of presence they bring to the therapeutic encounter contributes substantially to the effectiveness of psychotherapy. However the meaning of this notion lacks clarity within the literature as reflected in the varied meanings expressed in the two previous passages. Although interest in this construct has intensified in recent years (Geller & Greenberg, 2002) the meaning of therapeutic presence and its effect on clients is consistently explored by different theorists and modalities. Indeed the diversity of these explanations characterizes the findings of this study.

Discussion: The Evolving Construct of Presence

This study determines that therapeutic presence contributes significantly to client second-order change. As the varied constructions of this notion by expert informants highlight its complexity and diversity, this discussion compares the existing literature with the findings of this study.

Variant Notions of Presence

Although therapeutic presence has evolved into a transtheoretical concept, this notion derives from Rogers (1957) reflections as he developed empathy, congruence, and positive regard, described as the three core conditions of client centred therapy. Although Rogers (1980) does not explore the meaning of therapeutic presence until shortly before his death, he becomes increasingly aware of its importance.

I am inclined to think that in my writing I have stressed too much the three basic conditions Perhaps it is something around the edges

of those conditions that is really the most important element of therapy – when myself is very clearly, obviously present (Baldwin, 2000, p. 30).

Whilst Rogers (1980) does not complete a full exploration of therapist presence, his reflective remarks are the foundation of contemporary explications of this concept. Essentially, Rogers argues therapeutic presence embodies a form of altered consciousness.

I find that when I am closest to my inner, intuitive self, when I am somehow in touch with the unknown in me, when perhaps I am in a slightly altered state of consciousness, then whatever I do seems to be full of healing. Then, simply my presence is releasing and helpful to the other. I may behave in strange and impulsive ways in the relationship, ways in which I cannot justify rationally, which have nothing to do with my thought processes. But these strange behaviours turn out to be right, in some odd way: it seems that my inner spirit has reached out and touched the inner spirit of the other (p. 129).

Moreover, Buber's (1958) I/Thou dialectic posits healing emerges from a meeting between client and therapist as they become fully present to each other. American existentialist therapists such as Bugental (1976) refer to practitioner presence as "being totally in the situation" (p. 36) distinguishing intrinsic elements of accessibility and expressivity. Accessibility embodies the willingness of therapists to be affected by an event, whereas expressivity refers to their openness to sharing themselves as a form of output. This existential view resembles Jordan's (2001) analytic view of presence as a form of mutual intersubjectivity in which individuals express receptivity and initiative towards each other. Gestalt researchers, Hycner and Jacobs (1995) describe therapeutic presence as therapists turning away from their self towards a turning to the self of clients. In effect, when therapists are present, they do more than just attend to clients. Indeed they turn away from their own needs and offer themselves to being fully with clients. Clarkson (1997), a relational psychotherapist, depicts therapist presence as the emptying out of therapist knowledge and

an opening up to this within clients. In view of these diverse articulations, the experiential therapists, Geller and Greenberg, (2002) have developed a transtheoretical model of presence with three distinct domains described as preparation, process, and experience.

Three Phases of Transtheoretical Presence

Geller and Greenberg, (2002) posit that the initial preparation phase reflects behaviours by therapists that bring them to a therapeutic meeting with clients. This may occur at the beginning of sessions as well as in their daily life. Preparatory behaviour prior to sessions includes use of present-oriented breathing or self-statements, bracketing of expectations, and session plans that foster openness, curiosity, acceptance, interest and non-judgment. Life preparation refers to the philosophical commitment to practice presence development. These presence initiatives are evidenced by therapist willingness to enhance personal growth, adopt meditative practices, and practice mindfulness together with self-care strategies.

The second phase, the process phase, focuses on what therapists do when they are present in the here and now of sessions with clients. Geller and Greenberg (2002) identify three subcategories of the process of therapeutic presence. These include receptivity, inward attention, and extending and contact. These indicate the process of presence development incorporates a quality of fluidity that demands therapists be fully immersed in each moment. This flexibility includes the ability of therapists to move from taking in the fullness of client experience (receptivity) to being in contact with how this resonates in their body (inwardly attending) and directly connecting this experience with clients (extending and contact).

The third experience of presence phase refers to the actual in-session experience of presence by therapists. Geller and Greenberg (2002) identify four subcategories, the first being therapist immersion with clients that demands complete absorption. This views therapists as intimately engaged and absorbed in the experience of the moment with their attention centred on clients and happenings within the therapeutic encounter. This means that therapists are fully with clients, aware and alert, experiencing

the process of therapy without an attachment to a specific outcome. Therapists describe this moment with clients as an experience where nothing else exists except this encounter.

In concluding this discussion on therapeutic presence this commentary emphasizes it involves a state of being with the client rather than doing to the client. Essentially, presence is a state of being open and receiving of client experiencing in a gentle, non-judgmental and compassionate way. As Geller and Greenberg (2002) point out:

Therapeutic presence means being willing to be impacted and moved by the client's experience, while still being grounded and responsive to the client's needs and experience. Therapists' presence involves a balance and dual level of awareness of being in contact with the client's experience and with one's own experience, while being able to reflect on what is occurring with (p. 85

Sub-Theme 3.4: Therapist Receptive Listening

Receptive listening is identified as a sub-theme of therapist contributions that lead to effective psychotherapy and client change. Feltham and Horton (2006) posit that when clients are listened to they are encouraged to talk and reveal themselves. Moreover accurate listening helps clients become aware of the inner flow of their experiencing. Therapist listening may reduce client defensiveness, enabling them to focus on their behaviour rather than the behaviour of others. It also provides psychological space and support for client self-exploration.

At least half of the informants in this study stress the ability of therapists to listen to clients as potent influences in the emergence of client positive outcome effects. Although this ascertains effective therapy depends upon therapist ability to listen receptively to clients, the meaning of this interpersonal construct is wooly and vague. In grappling with definitional notions, two informants insist that successful psychotherapists "listen with their third ear". Another participant states that therapists listen with "free-floating attention" and "active receptiveness". Finally, another participant claims therapist listening "combines Bion's (1961)

reverie with his dictate that therapists eschew memory and desire". The research excerpts that follow reveal the salient features of this construct.

Research Excerpts

It's a kind of loosely suspended attention...I'm not focused on implementing a particular plan... I try to make sure my mind free...and I'm not sure that's really possible....but I certainly aspire towards it. I guess Bion's ideas of eschewing memory and desire is the best way to describe it.... It's about emptying the mind and accepting a state of 'not knowing'. So I'm free to receive the patient's unconscious communications. If you go into a session with too many ideas about what has to happen, you're not available to listen...you can't enter a state of reverie..... And this means emptying my mind....just letting thoughts float in and out so that my unconscious connects with the patient's unconscious.

This excerpt reveals when therapists listen to their clients in a specific manner, without goals, intention or agenda, a particular kind of therapist availability arises. Moreover, this availability integrates a number of diverse kinds of listening into one transtheoretical notion. Accordingly, these varied phenomena are operationalized by this thesis as the notion of receptive listening. The excerpt that follows is a further demonstration of this notion.

If you, as the therapist.... have any ideas about what you should or shouldn't be doing.....then you're manipulating and controlling....You have to put aside all your personal goals about client change and just listen...leave it to the life force in the client that wants to grow. The most you can do is be and this is about being available...to take in the conscious and unconscious psychic material the client offers.

Discussion: The Receptive Therapist

Despite the general recognition that listening constitutes a central feature of all psychotherapies, therapists continue to struggle with what it really means to listen to another. Barrett-Lennard (1988) suggests:

We get into and out of difficulties with each other to a large extent by the way we listen and by what we hear, mishear, and fail to hear. Furthermore, the topic is far from simple. It is many-sided and a continuing challenge to our understanding (p. 410).

The findings of this study highlight Barrett-Lennard's viewpoint concluding that psychotherapists engage in multifaceted kinds of listening informed by a complex stance of heightened receptivity. This position reflects the diverse kinds of listening referred to by expert informants in this study as well as the varied psychotherapeutic stances that are prescribed by informed commentary. Accordingly, this discussion explores participant responses in the light of the literature prior to merging these ideas into a singular transtheoretical construct. Thus, the theme of receptive listening consolidates current views that stress effective psychotherapy is fostered by this notion of receptivity.

Divergent Forms of Listening

The first form of listening to be addressed constitutes the notion of "listening with the third ear" (Reik, 1948, p. 144) stressed by two participants. Although this directive derives from traditional psychoanalysis, it has evolved into a basic premise of most psychotherapeutic modalities. Indeed Hill (2005) views this as a pantheoretical tenet initiated when therapists invite clients to tell their story, state their problems, articulate their goals, and explore their feelings. Moreover, Hill emphasizes that the key to listening with the third ear turns on the willingness of therapists to listen non-judgmentally to clients. Specifically, as receptive listeners, therapists implement open-ended questions, reflections of feelings and use of silence in their efforts to demonstrate their availability to clients.

The second notion of "evenly suspended attention" referred to by three informants derives from Freud's (1912, p. 111-112) view of the therapist's stance. As Schneider (2008) asserts, this requires therapists to demonstrate:

An attitude of openness and exploration; a willingness to tolerate a lack of closure, a synoptic calmness in the face of the pressure to

understand or cure, and a faith in eventually being able to make some sense out of experience (p. 327).

However Geller (2005), an experiential therapist, limits the scope of evenly suspended attention to the receiving phase of therapist listening. Moreover Safran (2003) refers to this phase as choiceless awareness whilst Freedman (1983) proclaims this notion focuses on client experience revealing “openness to the intent of the other” (p. 409). However, Geller posits that as the receiving phase of this form of listening develops, therapists broaden their focus to include mental activities carried undertaken at the periphery of consciousness. This kind of listening opens up to capture therapist desires as well as their fears, memories, and associations.

The third form of listening described by one informant as Bion’s (1961, p.309) “reverie”, represents unfocused attention within psychoanalytic psychotherapy. This form of listening is characterized by a temporary suspension of expectations regarding client experience and communication. Moreover reverie includes the setting aside of preconceived notions and thoughts and feelings that arise in clients or therapists during sessions. This state of therapist attentiveness exemplifies generative uncertainty and an open-minded unknowingness that generates meaning possibilities. Additionally, Hinshelwood, (1989) argues that reverie is an unfocused, receptive state of attunement within therapists that tracks internal impressions, thoughts, and images as well as client and relational affect, behaviours and thoughts. Essentially, when therapists enter a state of reverie, they do not make conscious attempts to sort, order, decode, or understand client expressions. However, over time, this unfocused attention yields to more focused awareness so that therapist attention no longer hovers. Alternatively their attentiveness hones in and discriminates, attributing meaning to what has been heard, seen, or sensed.

The fourth form of listening, quoted by two informants, refers to Bion’s (1967, p.173) dictate urging therapists “to eschew memory and desire”. This object relations stance challenges the consensually held view that desire, memory, and understanding facilitate the listening process.

Alternatively, Bion postulates these features obfuscate and interfere with accurate listening and the emotional experience of sessions. Therefore Bion entreats psychotherapists to shun prior knowledge and experience so they may treat each session as if it was their first encounter with clients. Hence Bion postulates that when psychotherapists 'eschew memory and desire' they experience a kind of meditative withdrawal that is similar to external sensory deprivation. Moreover therapist internal sensing qualities are activated and directed towards client experience and what this experience stirs within them. However Rubin (1985) condemns this attempt to empty the mind as an ill-founded practice based on the erroneous belief that "the desire to have no desires....is another desire that does not 'empty' the mind but keeps it full of, and occupied with the thought of being without desires" (p.605).

In addition, the findings of this study also determine that when therapists listen to clients, they do more than just hear the verbal statements of clients. Indeed one expert suggests they attend to clients by "attuning to their being emotionally, cognitively and bodily". Accordingly Bugental (1976) directs therapists to use this kind of listening to sense "the red thread" of client concerns (Mearns & Cooper (2005, p. 120). However for this to emerge, Rennie (1998b) recommends that therapists track client narratives through what Mearns and Cooper describe as holistic listening. This focuses on "breathing in" the totality of another rather than centering on one particular element. Buber's (1958) account of contemplating a tree reflects this process in which all aspects of the tree's "picture and movement, species and type, law and number" become "indivisibly united in the event (p. 20). Interestingly, holistic listening resembles an attitude of evenly suspended attention that Safran and Muran (2000) describe as "making no effort to concentrate the attention on anything in particular, and maintaining in regard to all that one hears, the same measure of calm, quiet attentiveness" (p. 55).

In reflecting on the divergent descriptions of listening reported by this study, it is suggested that these phenomena share one key characteristic. Specifically, psychoanalytic, client centred and existential

constructs highlight the openness of therapists in taking in the kinesthetic, cognitive, affective and visceral experience of clients and the space between the parties within the therapeutic environment. Consequently, it may be assumed that all modalities require therapists to engage in receptive listening as a determinant of effective psychotherapy.

Accordingly, therapists are required to commit themselves to remaining open and accepting to all dimensions of client and interpersonal experience that manifest within sessions. Essentially, this process allows phenomena to flow through therapists at an embodied level. Thus practitioners become vessels that contain cognitive, affective, and sensory information that guides therapeutic understandings and responses.

Sub-Theme 3.5: Participant-Observer Stance

The study establishes therapists adopt a participant-observer stance and this function informs effective therapy and second order change. Although only three informants refer to this notion, each insists this duality is a powerful informant of client change. Specifically, one participant views psychotherapists as 'conversational artists' who dialogue with clients whilst observing client and their own responses. In reflecting on this duality Jaffe (1986) posits the participant function relates to thinking *with* clients whilst the observation function pertains to thinking *about* clients. The duality is revealed in the first passage that demonstrates its complexity, reflected in the use of abstract theoretical language.

Research Excerpts

I am an observer and a participant ...and sometimes it's really tricky to do both....As an observer I look for internal shifts in me, in the patient and in our relationship. I stay with this as much as possible to look at what's really going on. And I know when I'm bumped out of this stance. I start interfering in the therapy process ...asking all sorts of irrelevant questions. The participant stance is completely different. It aims at full engagement. I'm in emotional contact in an interpersonal way. Balancing both is difficult.....because they're quite different... So when I get really

immersed in the other's world and over-identified with their issues, I have to remind myself to be objective about my own subjectivity

The distant-far approach of the previous passage contrasts with the intimacy of the experience-near tone of the following excerpt.

I'm always struggling with this paradox Sometimes when therapists are in the participant role they become so empathically engaged they can't really do the containing work... I worked with a supervisee earlier this week that fell into this trap. She was so attuned to a patient that she got stuck in the same place as the patient... so she couldn't bring any kind of reflective thinking to the situation. She was so over-identified with the problem that she completely overlooked the observer role. And of course this was not at all therapeutic: it really constrained the working alliance. It took me a long time to unpack all the supervisee's counter transference issues because she felt so completely overwhelmed by the situation.

This second passage implies effective therapists move from the position of observer to participant and back to observer position in an iterative fashion. The third excerpt that follows provides insight into the changing, moment-to-moment therapeutic process. This reveals inherent challenges and complexities that characterize the paradoxical stance of psychotherapists.

First you may have to observe what's going on inside you.... because you may not see it. You take in the projection.... and you may become unsettled in some way... the necessary diagnostic disturbance you could say... and then you become unsettled... you may not immediately understand it.... you just experience it... So you are just participating at this stage.... And then you notice something... and you start to reflect on it... so now you're starting to apply the observer... and then you process the disturbance within your own mind ... and maybe for a long time over weeks, months, years.... or maybe in a split second within the session.... Then when you understand something, you formulate your hypothesis.... It's like a scientific process really.... you collect up the evidence... formulate your hypothesis.... and if it seems viable.... you may share your hypothesis with

the patient... and collect some more evidence from the patient about it... explore it.... and then the patient will ultimately be the arbiter of the veracity of your formulation... so you will participate first... sometimes it's at the same time but often we apply the observer to the disturbance in our minds later.... and then using the observer... decide how to use this information therapeutically...and there may be pieces of information which the observer may decide not to use... and it may be information that would be too overwhelming for the patient.... and we may just let it go back into the data collection.

Discussion: The Participant-Observer and Process of Change

This thematic finding reflects Sullivan's (1940) views portraying psychotherapists as 'participant-observers'. This idiom suggests psychotherapists participate in client-therapist relations whilst observing the reactions and responses of both parties. In addition, therapists monitor verbal and non-verbal communications that sit in the space between both parties viewed by Ogden (1994) as "the analytic third (p. 3)". In describing this therapeutic stance, Crowley (1977) contends therapist participation embodies active responsiveness and communication whereas observation centers on the here and now scrutiny of clients, therapists, and interpersonal interactions. In attempting to describe the intersection of these roles, Crowley remarks:

I participate, I respond, I react to my patient and his verbal and non-verbal communications, and at the same time I observe what's going on, what the patient is saying and what he is not saying, evidences of anxiety, what I am feeling and thinking, and where, if anywhere, the interchanges are going, and wondering how best to formulate to the particular patient what I observe (p. 356).

Paradoxical Functions and Tasks

Essentially, this conceptualisation provides an illuminating characterization of the dual nature of the psychotherapist's task. On the one hand therapists are viewed as active participants who engage in dynamic relationships they co-create with clients. On the other hand, they

are assumed to adopt the stance of observers who critically evaluate behaviour, cognition, and affect of both parties. Furthermore, the syntactic joining of the words 'participant-observer' speaks to the intractable entwinement of both therapist activities in this context.

As the findings of this study determine participant-observer skills influence positive outcome effects, this implies enhanced interpersonal skills augment practitioner success. However, enrichment of relational competence challenges the current zeitgeist of specificity that favours modality over common factors. In other words, as authorities espouse their belief that specific therapies attain increased client outcomes, the value of participant-observation skills is marginalized (Chrzanowski, 1977). This is questionable as many informed theorists from diverse psychotherapeutic traditions view psychotherapy as an interpersonal activity, asserting training outside the relational realm is unnecessary (McLennan, 1999). For instance, Lomas (1993) argues relational intuition and lived experience embody sole factors in the attainment of psychotherapeutic success. Anchor and Smith (1978) contend knowledge and mastery of technical and theoretical aspects are irrelevant without relational skill development. Nevertheless, these views are subordinated by those who support the primacy of empirically supported therapies and manualized treatments (Chambless & Hollon, 1998).

Although this research supports the view that participant-observation enhances client outcomes, it is important to note this finding conflicts with this study's inherent contextualist epistemology. Essentially, a participant's reminder "to be objective about my own subjectivity" captures the inherent ambiguity of this stance. Specifically, the constructivist approach that informs this research asserts all observation is necessarily subjective. Hence, the subjectivity of the observer marks an intrinsic feature of this paradigm as well as the participant-observer position itself (Chrzanowski, 1977). Accordingly, whilst Sullivan's (1940) introduction of this notion contributes to the relational turn psychotherapy (Evans, 1996), its paradoxical effect is increasingly stressed in postmodern developments such as relational cultural theory. Although this confounds postmodern therapy,

the next objective of this review examines a less contentious duality: the executive and a caring role of therapists.

Sub-Theme 3.6: Executive and Caring Functions

A number of informants considered effective therapists distinguish their executive function from their caring function. Although this derives from the group relationships field, two participants considered this notion applied to psychotherapy.

Research Excerpts

Who am I in the role of psychotherapist? I was at a conference that explored this question...and from that a number of things occurred.... the most central was the split between the executive and caring function. I've found people who are drawn to the helping professions have a strong propensity towards the caring function but neglect the executive function just as people who are drawn to business are much more executive-oriented but neglect the caring function. I've come to understand is that these functions need to actually operate or integrate in tandem.

This first passage reveals the caring/executive dichotomy experienced by therapists in the management and practice of their function. This therapist role and its nexus with positive outcome effects represent a new finding within this domain. Accordingly, the second excerpt that follows exemplifies the indivisibility of the executive and caring functions within the therapeutic environment.

And I've understood that when one is working the executive function is essentially about managing boundaries such as time management, fees...and so on...and the caring function is the work. But if one of these functions is neglected.... it impacts on both....so the two have to work together

The participant explores his own experience with the duality of these functions and then refers to a specific clinical vignette:

For instance, in my own case fear of authority was very much part of the culture I grew up inso my own incapacity to take up authority was

something I learned to manage in my role as therapist. I'll give you an example of how this works. One of my clients who I see regularly works as a therapist. Recently, at the end of a session.... I indicated two times when I was available but she said she couldn't come to either. So I said... "Well those are the times that I can offer you"..... And she struggled with that and had to move her life around to fit those times. But I wasn't being obstinate.....even though she might have thought so at the time.... Those were the times that I could offer and later, after a few more sessions, she stated that she really appreciated the definiteness of knowing my availability. The clarity of my statement was not authoritarian but explicit. So in terms of effectiveness there was a deeply dynamic element in thinking about what happened. From a management perspective....therapeutic success had been made possible by valuing the executive function... it had made space for thinking.....and this eventually strengthened the helping function.

Thus the study determines that psychotherapists undertake an executive and a caring function to enhance the effectiveness of treatment. Although only two research participants characterize this duality as a major contribution to successful therapy, their enthusiastic commitment to this perspective was a major insight of the study. Indeed this duality indicates the necessity to maintain manifold physical and non-physical boundaries to ensure treatment success. Whilst this stance derives from the socio-analytic discourse of Obholzer and Roberts (1994), it is rarely explored within the psychotherapeutic realm. Accordingly, the nuances of this dichotomy are examined within this study in the context of psychotherapeutic success.

Discussion: Executive Caring Duality

In the context of organizational functioning, Obholzer and Zagier Roberts (1994) identify the task of management as "a form of conduct by those in authority that is intended to keep the organisation functioning and on-task" (p. 43). Consequently, this "boundary regulating function" (p. 45) is viewed as a hard-edged, executive role that involves regulating variables such as task, territory, time, role and resources (Shafer, 2003, p. 1).

However, conversely, this exposition is applied to psychotherapeutic praxis in which soft-edged, caring functions are viewed as responsive empathically-based therapeutic interventions. Indeed, Shafer makes the point both these functions are necessary ingredients of all effective psychotherapeutic engagements. Moreover, the use of terms such as 'hard-edged' and 'soft-edged' are deliberate as they suggest psychotherapists demonize and idealize the boundaries of these functions.

Specifically, this approach acknowledges the existence of tensions between the caring and executive functions of psychotherapeutic practice that impact on client outcome effects. This thrust contends therapists privilege their caring function at the expense of organizational rigour. Conversely, managers in organizational contexts favour their executive function whilst diminishing the caring dimensions of their role. As this polarized overview appears somewhat simplistic, further discussion of these functions within the context of psychotherapy is required.

Soft-edged and Hard-Edged Functions Combined

The management of boundary conditions such as task, role, time, territory, and resources represents a vital therapist function, yet this executive role is frequently devalued by practitioners. As boundary violations invariably relate to interpersonal dilemmas within the therapeutic relationship, it is not surprising this failure of the executive role impedes the effectiveness of therapy. However, paradoxically, both executive and caring functions are required to attend to these boundary violations as both are needed for optimal containment. Accordingly, when optimal containment is realized through the judicious application of both functions, therapeutic interventions are maximized. Within the context of psychotherapy tensions seems to emerge from the high value placed on the caring capacity, while the executive function is often demeaned and denigrated. However paradoxically, the privileging of the caring role at the expense of the executive role prevents the establishment of necessary limits that enhance the therapeutic relationship and the actual work of therapy. As Shafer (2003) contends:

When clinicians I have supervised have engaged with a fuller realization of this and of the value of the executive function, they have found not only a very useful instrument in their therapeutic work, but a more secure, bounded therapeutic container. When such clinicians also held the role of manager, the increased recognition of the value of the executive functions also facilitated their managerial competence (p. 17).

In summary, as this finding emerges from small-scale, in-depth qualitative research, its implications for the broader empirical inquiry are promising provided that positivistic confirmation of validity and generalizability is sought. However, as the duality of executive and caring functions offer innovative guidance to practitioners, I suggest further development of these ideas be undertaken through exploratory, practice-based research in the immediate future to enhance understandings of this binary.

Sub-Theme 3.7: Therapist Acumen

Although the meaning of acumen in psychotherapy is unclear, the study determined this therapist attribute informed effective therapy. Accordingly it is identified as an important sub-theme, explored by informant responses as detailed below. This study ascertains that therapist acumen is a key ingredient of effective therapy, although the meaning of this attribute requires elaboration.

Research Excerpts

The key is to know what is therapeutic as it changes from moment to moment.....as well as the capacity to assemble thoughts from evidence that tells you how to think....from what is said or acted out....like body language and projections and transference....It's a delicate business and some people are better at it. It's hard to say why. Although you can develop it, this has its limits. Sure....one can be taught to make decisions but they are just some people who seem to be born with it...how do you account for it?

In reviewing the first passage above, it infers the ability to track body language and unconscious processes such as projection and transference exemplifies therapist acumen. However this passage fails to offer an explanation of the operation of this notion. Perhaps this is due to the fact that these non-verbal contextual forces that operate within the therapeutic environment are far more influential and persuasive than what is overtly captured by language? Likewise, the second passage detailed below reveals therapist difficulty in coming to grips with the origin and qualities of acumen.

Now that's very tricky as some people have better clinical insight because I think they have a better understanding of people and this leads us to the Arts/Science conundrum. Is the practice of psychotherapy, a science or an art? Both...in my view....And can people be trained in clinical acumen? Yes...and... No because it depends on what the person brings. There are some people who are more talented than others. They have a better understanding of the human condition... and of themselves. However there are some people who may not have this level of talent yet become very responsible therapists. If they're well trained and ethical and do no harm and are taught how to use evidence effectively... they can be good therapists.... but they may not be as good as someone who has insight, wisdom and intelligence. That's what I mean about the mix of art and science. At the end of the day it's that unknown quality that's hard to name.....Certainly the therapists I regard as excellent would have a special compassion....a special kind of human respect...and a special kind of attunement.

Finally, the third clinical vignette that follows reveals the subtlety of therapist acumen in responding to the vulnerability of clients.

I have a patient whose mother had a caesarean when he was born and this damaged her internally...she complained about so that, for most of his life, my patient believed he was responsible for hurting his mother. From an early age he became obsessed about fixing things....and this helped him in various businesses. Now he's in his fifties and has provided well for his

family...but he still sees himself as someone who can't please others. In early sessions he spoke a great deal about his childhood in a rural Australian town and I got glimpses of this incredibly lonely boy who played alone. On one occasion, about a year into his therapy, I was overwhelmed by sadness as he spoke of his past and I shared this with him. And he became very flushed...his eyes welled up...a small tear formed at the corner of one eye. I looked at him very intently....into his eyes....and then at the tear....and then into his eyes again....then I smiled in a very accepting way....He bowed his head and starred into his lap. So we stayed silent for the rest of the session. When I moved to bring things to a close, he said something like: "Now I understand why I'm good at my work. Although I've always wanted to do something more creative, I haven't because it would mean I could actually give up fixing the things". In that moment he realized that as much as he could do things well, there was a bigger, more unconscious undoing going on.

Although the artistry in this vignette is difficult to describe, the relational contact between client and therapist is emphasized and evidenced by the client's flushed face, tearfulness, and therapist's validating smile.

In considering the diversity of definitional notions, Dollinger and Riger (1984) assert that acumen constitutes empathic understanding of another's viewpoint attained by passing through their defense barriers. Luchin's (1948) perceptions are more specific as they have perceived acumen as a form of assessment that evaluates the personality structure and clinical symptoms of another. Alternatively, Stern (1982) has claimed that acumen approximates therapist expertise whilst Geller, Norcross, and Orlinsky (2005) have maintained this notion is a composite of traits that include competence, experience, reputation, warmth, and openness.

These variant descriptions infer therapist acumen amounts to an expression of sagacity that involves specialized knowledge as well as alert attention to specific cues that are critical in predicting the behaviour of another. Although this notion smacks of the interpretive formulations of the medical model (Markowitz & Swartz, 2006), the presence of therapist

acumen is informed by the parties' contextual circumstances. Although Dublin (1971) contends the "medical stance itself is inherently antithetic to therapist communicative intimacy....and calls for emotional reserve and diagnostic acumen" (p. 405), Fix and Haffke (1975) espouse this may be overcome by therapist training such as Rogers' (1961) facilitative conditions. Specifically, they argue that therapists who "search for pathology by focusing on specific disorders whilst ignoring manifest health" (p. 490) fall within this category. However, Fix and Haffke make the point that when therapists use their acumen to encourage client recognition of their strengths and non-pathological controls, these actions are profoundly healing.

Discussion: Therapist Acumen and Encountering the Sacred in Psychotherapy

The preceding excerpt demonstrates the complex interpersonal dynamics that constitute 'vulnerable moments' (Livingston, 2001) and the role of therapist acumen in this process. Although these moments are explored in detail later in this thesis, therapist responses implicit in these phenomena underscore the importance of practitioner acumen in psychotherapy. Indeed Griffith and Griffith (2002) postulate when acumen is used to facilitate the emergence of a vulnerable moment within clients, it is akin to "encountering the sacred in psychotherapy" (p. i). Indeed these researchers contend that:

When people consult us as therapists, we want them too, to be able to tell...stories that inspire hope and connection for them, as well as any that bring despair and isolation. We are ...passionately interested in how we can make this possible, how we as therapists, may encourage and inadvertently thwart the meaning and making of these experiences (p. viii).

Although Stolorow (1993) implements an intersubjective perspective to advance "sustained empathic inquiry" (p. 34) within the therapeutic encounter, he underscores the importance of this investigative function (p. 34) as akin to therapist acumen. Specifically, Stolorow suggests subtle

choices of conceptual phrases in therapeutic praxis convey important differences in attitude. Indeed, Stolorow rejects Kohut's (1985) self-psychological notion of "empathic immersion into patient subjective experience" (p. 82) and points to the potential countertransference pitfalls in adopting this mindset. Essentially, he criticizes this approach as it requires therapists to immerse themselves completely into client experience. Accordingly, Stolorow postulates that adoption of this position by therapists is indefensible in "banishing his own psychological organization....surely an impossible feat" (1993, p. 34). Instead Stolorow contends sustained empathic immersion into client experience diminishes the effect of an experience-near position yet acknowledges the impact of therapist subjectivity informed by a constructivist stance.

Therapists and Vulnerable Moments

Essentially, vulnerable moments are "those brief periods when a person is able to let go of his defenses and to allow himself to be open, soft, and very, very, human" (Livingston, 1975, p. 242). Although the clinical vignette featured above demonstrates these moments are profoundly curative, it also reveals they have the potential to create significant distress despite a supportive and validating therapeutic environment. As the self-psychologist, Ornstein (1974) contends, clients enter therapy with mixed feelings he describes as: "the dread of re-traumatization, humiliation, and a repetition of the self-object failures of childhood, and at the same time the hope of self-object responsiveness and connection" (Livingston, 1999, p. 23).

This suggests that client vulnerability, paradoxically, encompasses fear of narcissistic injury as well as openness to new self-object experiences. These include validation, affect regulation, connection, and affirmation of basic humanness. Indeed, Livingston (1999) proclaims these opportunities take in the tenderness, empathic responsiveness, and nurturance that clients long for beneath their protective shell (p. 24). Accordingly, skill in balancing these qualities with insight, judgment and wisdom are ongoing challenges for therapists in these encounters. Specifically, in the previous clinical vignette, the timing of the therapist in

disclosing her sadness, honouring the tear in the eye of the client, and nourishing the client with her smile are inspirational examples of therapist acumen.

Summary of Theme 3: Therapist Contribution

This study establishes a significant number of therapist qualities inform therapeutic outcomes. These influential determinants include commitment to search for emotional truth as well as the authenticity, presence and receptivity that therapists bring. Moreover these findings link the participant-observer stance assumed by therapists with enhanced client effects. Finally, therapist acumen was viewed as an important influence on effective psychotherapy, although the features of this attribute and its development remain a contentious issue.

Although these findings indicate more research on therapist effects is necessary to improve client outcomes, Lambert and Baldwin (2009) speculate other forms of investigation are also relevant. Specifically, these researchers challenge past empirical assumptions of outcome research, shifting the focus of inquiry to process research. Although this approach affirms the recommendations of Krause and Lutz, (2009) that opt for inquiry into psychotherapists attributes, Lambert and Baldwin also condemn violations in statistical assumptions that compare the effects of two or more treatments in clinical trials. In particular, Lambert and Baldwin posit that this form of assessment does not reflect the mutual interrelationships and influences between client, therapist, and treatment effects. Essentially, these researchers highlight the function of therapists that adjusts therapeutic processes to meet client needs. Consequently, whilst Krause and Lutz admit studying therapist outcomes may lead to the identification of important processes that could be leveraged by clinicians to enhance outcomes, Lambert and Baldwin point out this praxis raised some practical issues. Certainly as this "empirically unsettled problem" (Lambert & Baldwin, p. 83) has led to the exploration of an impressive list of therapist variables over the last sixty years, there is little reason to believe therapists are likely to succeed at such a task. Accordingly, Beutler, Malik, Alomohamed et al. (2004), posit that variables that emerge from the actual

process of therapy are likely to provide better answers than outcome research. Although Lambert and Baldwin conclude that process studies are very expensive and infrequently funded they posit that:

Unless there is a significant change in what kind of research is funded by granting agencies, it is unlikely that answers will be coming soon, assuming answers are to be had (p. 83).

Accordingly, the processes Lambert and Baldwin cite are found in the reciprocal dynamics intrinsic to the therapeutic relationship. These are explored in the next chapter of this thesis that examines interpersonal processes within the therapeutic environment and their effect on client change.

Chapter Four Schematic Outline (Part A)

Phase II: What Makes Therapy Work

Overarching Theme 1: Client internalized change viewed as informant of effective therapy

Affirms therapeutic effectiveness equates with client change

Raises questions re meaning of change; paradox of internal versus external change, first order versus second order change & effect of transformational psychotherapy

Contrasts with substantive empirical evidence espousing removal of symptoms sufficient proof of effectiveness

Sub-Themes:

1.1 Client enhanced sense of self feature of internalized change nurtured by therapy relationship

Positive change enhanced through therapy relationship

At odds with medical model's privileging of specific factors & evidence-based treatments that minimize relationship effects

1.2 Client objective and subjective change are indicators of effectiveness

However constructivist challenge re notion of objective change: illusion of 'objective' truth questionable as change is always subjective

Overarching Theme 2: Clients contribute substantially to effective therapy

Although evidenced by empirical literature but study distinguishable as Phase II findings stress contribution of client symptoms, client psychological mindedness, reflexivity, openness, receptivity & readiness for change

Meaning of each notion investigated due to ambiguity

Contribution of each notion largely overlooked in empirical literature due to focus on specific factors

Sub-Themes

2.1 Symptoms are opportunities for healing: function as rituals that are doorway to change

Focus on collaborative inquiry & exaggeration of symptoms rather than removal of symptoms

Contrary to evidence-based treatments & specific factors arguments aiming to eliminate symptoms

2.2 Client psychological mindedness contributes to effective therapy

Yet meaning of psychological mindedness equivocal although generally connotes self-appraisal, self-awareness & introspection

2.3 Client reflexivity an informant of effectiveness as facilitates meaning-making

However therapists also thought to have an instigating role in curative process: focus on clients alone ignores role of interpersonal therapeutic connection

2.4 Client openness, receptivity & readiness for change contribute to effectiveness

Although vague constructs affirm client role in change: verifies common factor argument

Chapter Four Schematic Outline (Part B)

Phase II: What Makes Therapy Work

Overarching Theme 3: Therapist actions & ways of being contribute to effective therapy

Includes therapist commitment to emotional truth, authenticity, relational awareness, presence, receptive listening, acumen, adoption of participant/observer stance & executive/caring roles

Sub-Themes

3.1 Obligation to seek emotional truth paramount in facilitating effective therapy

Varied interpretations but generally involves complexity of thinking & feeling in striving to make the unknowable known: huge impact on effectiveness

3.2 Therapist authenticity strong informant of effectiveness

Ambiguous notion yet general agreement in literature means that therapist is responsive, real, and relationally aware

3.3 Quality of presence therapist brings to relationship impacts on success of therapy

Involves a state of being 'with client' rather than 'doing to client'

As transtheoretical notion in constant state of evolution, variant explications from Rogers & Buber relevant but Geller & Greenberg's three-phased model most applicable

3.4 Receptivity of therapist enhances effectiveness

Therapists adopt multifaceted kinds of listening that indicate heightened receptivity: four exemplars identified: demonstrate emotional, cognitive & bodily attunement that absorb kinesthetic, cognitive, affective, visceral client & relational experience

3.5 Adoption of participant/observer stance facilitates therapeutic success

Highlights duality of therapist's role: paradoxical as requires therapist to be 'objective about their subjectivity': but is this really possible? Conflicts with contextualist epistemology of thesis

3.6 Therapist adoption of executive/caring function enhances effectiveness

New concept to psychotherapy that stems from group relations

Dichotomy of executive/caring functions provide holistic backdrop to effective therapy management

3.7 Therapist clinical acumen affects client outcomes

Acumen difficult to define but encompasses sagacity of specialized forms of knowledge & attention to critical cues predicting behaviour

Strong effect on covert therapeutic processes that facilitate client change

CHAPTER FIVE

PHASE TWO FINDINGS: WHAT MAKES THERAPY WORK?

Interpersonal Processes

The little things? The little moments? They aren't little.

(Jon Kabat-Zinn, 2005, p.69)

The focus of this chapter examines features of the client/therapist relationship that contribute to effective psychotherapy. In particular, the process dynamics identified by West Australian expert psychotherapists are explored. Three overarching themes are highlighted. The first of these include the relational depth between client and therapist and its impact on outcome effects. Associated sub-themes such as the degree of mutuality between the parties, the quality of their meeting and presence were found to impact on client change. Client and therapist receptivity and the 'as if relationship' are also thought to be informants of effective therapy. The second overarching theme indicated that significant moments in the therapeutic environment had a profound effect on therapeutic movement. These phenomena were found to operate at covert and overt levels of client/therapist awareness. Although diverse kinds of temporal moments have been recognized in the informed literature, therapeutic moments and vulnerable moments are significant in this study. Finally, the third overarching theme acknowledged that interpersonal processes that enhance therapeutic effectiveness are informed by a three-phase model of empathic inquiry.

In the previous chapter, a diverse range of attributes are identified as markers of effective psychotherapy. Within the outcome literature these features are generally described as common factors. Although prior research recognizes these as influences on therapeutic success, the majority of these findings are empirical, evidence-based conclusions. In contrast, this exploratory study examines the practice wisdom of West Australian expert psychotherapists asked to identify what makes therapy work. Although this adds to explicit knowledge gleaned from previous empirical outcome and process studies, it also opens up new realms of understanding based on practice-based implicit knowledge. Thus, although elements derived from prior positivistic inquiry are addressed, these are explored through a different lens. Specifically, constructivist, phenomenological assumptions are implemented to investigate these attributions based on practice wisdom rather than empiricist ideals. Accordingly, as emergent common factors are discussed in the previous chapter, interpersonal processes and their link with effective psychotherapy are presented in this chapter.

Even though process research is said to impact on client outcomes, this form of investigation is consistently neglected by researchers. Essentially, even though numerous studies stress the advantages of process research, fiscal and philosophical restrictions downgrade this thrust. In contrast, it is asserted interpersonal processes make a profound contribution to effective therapy as they enhance client and therapist development. Accordingly, these findings and their implications are critiqued and assessed in the light of current developments and informed commentary within the psychotherapeutic domain. To begin with the meaning of interpersonal process is reviewed.

Interpersonal Process in Psychotherapy

As the nexus between therapist/client processes and positive outcome effects are a primary consideration of this research, definitional meanings of interpersonal process are relevant. Although definitional notions differ, these phenomena are commonly described as “mechanisms of change” (Pachankis & Goldfried, 2007, p. 762), “clinical strategies” or

“principles of change” (Held, 1991, p. 208). These notions are thought to characterize the relational realm of any therapeutic encounter regardless of theoretical orientation (Kiesler, 1971; Rice & Kerr, 1986). This investigative thrust is significant as controlled clinical trials or pre-post designs are incapable of identifying mechanisms of change. Consequently, enhanced knowledge of these elements is likely to lead to more information regarding what makes therapy work. As this study establishes that a number of these processes inform client change, these phenomena are examined in this chapter.

Essentially, this study affirms prior studies suggesting the mutuality of client/therapist connection contributes significantly to effective client outcomes. These conclusions also ascertain therapists glean benefits from this process that augment internal development. In effect, this research determines the praxis of psychotherapy advantages both parties. Specifically, this mutual growth is informed by a number of interpersonal processes identified by this research as relational depth. Additionally, inherent mechanisms implicit in this overarching theme support this conclusion. These include a number of emergent sub-themes identified by this study as client/therapist mutuality, client/therapist moments of meeting, and the duality of presence, realness and receptivity. Accordingly, this overarching theme and associated sub-themes are addressed in the light of informed commentary.

Overarching Theme 1: Relational Depth

All participants in the second phase of the study emphasize the importance of client/therapist encounters characterized by deep connectedness and intense engagement. Essentially, they view these episodes as mutually beneficial moments within the therapeutic endeavour. Most participants confirm these moments exemplify high levels of mutual acceptance and empathy. In particular, they stress the reciprocity of client/therapist affect during these events. Specifically, four informants emphasize these meetings are real and genuine encounters despite the ‘as if’ (Whelan, 1992) nature of the therapeutic relationship. Additionally, participants state during these moments of meeting, therapists were totally

present and available to clients. Accordingly, these events are viewed together as the overarching theme of relational depth. Indeed the clinical vignette that follows demonstrates this construct and how it advances therapeutic movement.

Research Excerpt

I'd like to talk about a young man I've been seeing for five years. He's been coming weekly for most of that time. He's very bright, charming....a puppy doggy sort of guy who always wants to please yet is very guarded as well and finds it very confronting to show his feelings...He's an only child who was adopted and his relationship with his parents is not an open one. I suspect his adoptive father is quite ambivalent about him. In fact, I think he was adopted for the mother as he's always had a very difficult relationship with the father, feeling uncertain where he stood with him. Over the last six months I noticed a qualitative change in him. He's become more involved in the therapy because I think it has taken this long to trust me. So I've begun to make a few transference-based comments that he has found enormously difficult. In fact he came in recently and said he was feeling 'pissed-off' with therapy because we'd been talking about how he felt about me and couldn't understand why. Initially I explained the role of transference in a factual sort of way but then brought the conversation back to linking his experience of me with his experience of his father. Suddenly his body language changed! He sat back on the couch, closed his eyes and began talking about his father in a much more emotive sort of a way. The puppy doggy charm was replaced by a desperation that I hadn't seen before. At the same time I became aware of tightness in my chest and feelings of vulnerability and helplessness that I knew were his. Then he admitted that when I linked his experience of me with his father he felt very frightened and angry. I think he also said something about feeling wary and anxious that I might ask him how he felt about me. I responded by making some sort of comment that perhaps his experience with me was like being with his father...a man he both yearned to be close to...but was also frightened of. And as I offered this comment I noticed he fell forward....as if a great weight was lifted...so I said something like: "I guess

it was a very difficult relationship” and he said “Yes, it was difficult, it was bloody horrible” and he began to talk about his father in a very real way ...And as he did so...he became more relaxed. It was a defining moment because he actually felt safe enough to drop trying to get me to like him... He could actually experience how he felt about his father and its devastating impact. So from that time on he’s been communicating in a more robust way.

This passage reveals the potential for connection between client and therapist in moments of relational depth. Specifically, it demonstrates various attributes of relatedness that are implicit in this notion. This includes a willingness to be ‘real’ and truly ‘meet’ with the other and oneself in the therapeutic encounter. Specifically as therapists challenge clients to face their own vulnerabilities, they also have opportunities to reflect on their own discomfort in an authentic and transparent manner. Thus a willingness to really ‘meet’ the other and be ‘real’ falls within the ambit of relational depth as defined by various theorists (Mearns & Cooper, 2005). However, apart from these relational features, this vignette also demonstrates a key finding regarding the informants of effective therapy. Essentially, this example indicates the relational depth of the encounter was found to have a substantive effect on client outcomes and effective therapy. Specifically, this vignette acknowledges when participants identify client transference in direct and confronting ways, both parties experience more authentic, real relating. Consequently, this encourages therapeutic movement and positive development that leads to significant client change. Thus the level of relational depth is a pivotal factor in the success of therapy. In view of the significance of this influence, the next task of this review examines the notion of relational depth in the light of informed commentary.

Discussion: Ambit of Relational Depth

Although relational depth as a theoretical construct may be found in previous research, this is generally limited to client-centred approaches (Cooper, 2005). However this study expands the ambit of this construct by taking relational depth to a new pantheoretical level. Specifically, as the

majority of participants who identify the presence of this notion are informed by a diverse range of depth therapies, this implies the notion of relational depth manifests in a wider range of therapeutic modalities. Accordingly, as definitions of this notion vary, for the purposes of this thesis, relational depth is operationalized to refer to an 'event' or 'series of events' that demonstrate interpersonal connectedness (Buber, 1970; Ehrenberg, 1992; Friedman, 1985; Hycner, 1991; Stern, 2004). Moreover, it is suggested these 'events' mark important turning points in the therapeutic relationship that advance client movement (Mearns & Thorne, 2007). Furthermore, to clarify the meaning of this notion, the term "working at relational depth" adopted by Mearns, 1996, (p. 307) underscores the quality of contact between client and therapist. This has been described by client centred therapists as:

A state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other's experiences at a high level (Mearns & Cooper, 2005, p. xii).

Thus the findings of this study indicate a wide variety of expert practitioners from diverse range of depth therapies consider the quality of relational depth a key informant of effective therapy and client change. Thus, it is argued that this notion extends beyond client centred therapy as previously thought. However it is important to note whilst participants in this study do not overtly refer to this notion, all privileged moments of sustained, client/therapist connection are turning points in the attainment of beneficial client outcomes. Although the language used to illustrate these moments differs, these descriptions share common ideas. Furthermore these commonalities may also be identified in the history of psychotherapeutic research (Cooper, 2004; Norcross, 2002).

Essentially, from Frank's (1961) early inquiries to Wampold's (2001) 'mega-analytical' investigations, theorists argue that effective therapy derives from covert and overt pantheoretical processes that manifest within the therapeutic environment (Hubble et al. 1999, Lambert & Barley, 2002). However, the views of this clamorous lobby group are consistently

marginalized by modality-driven empirical interests. For instance, even when it comes to vital constructs such as therapeutic alliance, empirical investigations encourage de-contextualized, positivistic examination of client goals and tasks (Tryon & Winograd, 2002). Astoundingly, influences that affect this interpersonal process within real-life therapeutic encounters are consistently ignored. Moreover this omission is surprising as many therapists view the act of relating to be the heart of therapeutic praxis (Friedman, 1985; Mearns & Cooper, 2005; Stern, 2004). Furthermore, notions of client/therapist relatedness lack influence as they are conceptualized across multiple therapeutic orientations in diverse ways. Regrettably, this creates difficulties in terms of comparative research. Besides, varied conceptualisations of relational depth are reflected in the diverse descriptions elicited in this study that are highlighted the informed literature. Therefore, as these pantheoretical considerations require further discussion, this is explored as the next task of this commentary.

Diverse Conceptualizations of Relational Depth

Pantheoretical assessment of relational depth is challenging as descriptions in a wide range of therapeutic contexts allude to these dynamics in varied ways. For instance, in the field of infant analytic research, Stern (2004) refers to “moments of meeting” (p. 283) when a “mutual interpenetration of minds” (p. 11) takes place. Alternatively, Ehrenberg’s (1992) analytic perspective alludes to “the point of maximum and acknowledged contact at any given moment in a relationship without fusion’ (p. 33). From the field of feminist therapy, Jordan (1991) refers to mutual intersubjectivity when “one is both affecting the other and being affected by the other; one extends oneself out to the other and is also receptive to the impact of the other” (p. 82). Existential and humanistic therapists such as Friedman (1985) and Hycner (1991) describe transformational dialogic meetings in the therapeutic encounter by drawing on the work of Buber (1958). Indeed, within client-centred therapy, Mearns (2003) writes of an “extraordinary depth of human contact” (p. 5) that results in the “blending together of high degrees of the three core conditions of empathy, unconditional positive regard and congruence” (p.

8). Thus this review of the literature indicates relational depth is strongly associated with notions of client/therapist mutuality, moments of meeting, presence, realness, and receptivity. Hence it is not surprising these notions are identified by participants in this study as informants of effective therapy. Hence, for the purposes of this thesis, these descriptions are identified as elements of relational depth. Furthermore each component is operationalized as individual sub-themes of the broader notion of relational depth. Accordingly, they are explored in the next stage of this commentary. Is this depth or is it getting to a joint experience of the clients reactions to the father, or both?

Sub-Theme 1.1: Mutuality

Almost all participants claim reciprocal, mutual development is a key outcome of effective client/therapist connections. Accordingly, client/therapist mutuality is identified as a sub-theme of relational depth. However as mutuality is a controversial precept, informed by ontological and epistemological positioning within the domain of psychotherapy, its meaning in the context of this research is operationalized. Specifically, Jordan's (2000, p. 1007) explication of mutuality is adopted, based on emergent research material that suggests:

- i. People grow through and toward relationship throughout the lifespan;
- ii. Movement toward mutuality rather than movement toward separation characterizes mature functioning;
- iii. Relationship differentiation and elaboration characterize growth;
- iv. Mutual empathy and mutual empowerment are at the core of growth-fostering relationships;
- v. In-growth-fostering relationships, all people contribute and grow or benefit; development is not a one-way street;
- vi. Mutual empathy is the vehicle for change in therapy;
- vii. Real engagement and therapeutic authenticity are necessary for the development of mutual empathy.

The excerpts that follow reveal the significance of this construct.

Research Excerpts

We're both learning...it's a kind of symmetry based on openness and sharing. We are both affected and we grow from it.... But clients disclose more because they've come to be helped.....They're at the centre of the exchange.... Although we hold on to our sense of self... aspects of our unconscious merge...And this joint expansion produces something new at a subtle level... it's a healing journey for both of us.

In reviewing participant material, the previous excerpt stresses reciprocal qualities of the therapeutic dyad, highlighting mutual affect that comes with client/therapist openness and sharing. Contrarily, the excerpt that follows implies mutuality is more cognitive and pragmatic. The participant recognizes therapy embodies a shared moment of synchronicity with potent learning opportunities.

My sense is people get sent to me for their sake as well as mine. If I'm grappling with something and all of a sudden I get a few new referrals with the same issue I know there's something's there for both of us. We're supposed to connect around it. For whatever reason clients come into my life to teach me something and I'm meant to teach them as well..... It's a joint exchange. I've experienced this synchronicity often.

Although client/therapist mutuality is underscored it manifests in the real life clinical encounter of the following passage.

I was seeing a client and the work we did together was quite extraordinary....it had such a strong sense of the bizarre about it. To this day I am not sure whether we worked with an aspect of this client's unconscious or some sort of presence from another dimension. At the time I was very aware that that I'd never done work like this before...and it made me very nervous.... but it showed me that I can trust whatever happens in the therapy room...no matter how weird or uncanny... and work with it. I think that's why this client came to see me...so we could both have an experience of going with the unknown. It was a big learning for me about

trusting my intuition. As all three passages illustrate the potent power of mutuality, the exact meaning of this notion is cogent and relevant.

Although common usage defines mutuality as a reciprocal sentiment or relationship existing between interdependent entities (Curley, 1997), this remains something of a puzzle within psychotherapy. In addition, the medicalization of this domain enhances this conundrum as therapists are considered objective experts who tend to 'sick' patients suffering from mental and emotional stress. Indeed, clients experiencing these kinds of problems are defined by their pathology. In effect, the problem becomes the person (White, 2002).

Discussion: The Conundrum of Mutuality

The thrust of all three excerpts demonstrates the reciprocal mutuality of client and therapist in the enterprise of psychotherapy. Collectively, these passages contend both parties engage in a two-way process of reciprocity that affirms individual experience. Additionally, the notion of mutuality transcends experience of self as both client and therapist are considered to combine their interiority temporarily into a larger relational unit. Thus, this transitory interaction suspends separateness through the recognition that the well-being of the other is as important as one's own (Jordan, 1995). Moreover, these passages reflect the increased emphasis on the interdependent aspects of the therapeutic relationship that bring the principles of mutuality and reciprocity to the fore.

Interestingly, in view of the medical model's rejection of mutuality, it is surprising to note growth and reciprocal development in both client and therapist emanate from constructivist nursing literature. Specifically, Curley's (1997) exposition of patient/nurse mutuality counters the pathology of the medical model. This stance contends two attributes characterize this mutuality: (i) a synchronous co-constituted relationship, and (ii) evolution of both individuals toward personal becoming. Each feature contributes uniquely to a more complete understanding of mutuality. This is first depicted as a synchronous co-constituted relationship that constitutes responsive interdependence, intersubjectivity, shared

commonality, and equity within the relationship. Indeed, feelings engendered by mutual respect belong to each party, respectively. The second attribute, movement toward a personal becoming, speaks to the goal of the interaction that benefits each participant. Moreover, participants develop greater self-awareness and self-understanding through relationship that contributes to their personhood. However, although these precepts have entered the field of psychotherapy, they are received with uncertainty due to the strength of the science-practitioner model. Although postmodern perspectives view mutuality, symmetry and optional responsiveness as proper baselines of the psychotherapeutic relationship (Mitchell, 1993), this is refuted by proponents of the medical model. Essentially, the latter disavows that therapists are required to be emotionally expressive and self-disclosing of feelings and attitudes. Furthermore, it intensifies debate about "heightened ambiguities regarding the optimal placement of the boundary between therapeutic intimacy and personal intimacy" (Geller, 2005, p. 383).

In addition, theories informed by postmodernist ethos cause concern to positivistic interests as they encourage therapists and clients to extend themselves more to one another. This approach, exemplified in Jordan's (1995) feminist relational-cultural theory aims to overcome strategies of disconnection. Specifically, this precept argues that individuals grow in, through and towards relationship and this connection is central to well-being. Moreover this movement towards relational mutuality occurs throughout life. Additionally, Stolorow and Atwood's (1992) intersubjectivity highlights the privileging of the relational and interpersonal in psychotherapy. They conceptualize the therapeutic relationship as an interactive process of "reciprocal mutual influence in which clinical phenomena...cannot be understood apart from the intersubjective contexts in which they take form" (p. 18). Consequently, Stolorow and Atwood argue client and therapist form an "indissoluble psychological system" (1984, p. 64) that embodies a "codetermination" (1992, p. 24) in this reciprocal process. Aron's (1991) traditional analytic stance posits that:

The fact that the influence between the patient and analyst is not equal does not mean that it is not mutual. Mutual influence does not imply equal influence, and the analytic relationship may be mutual without being symmetrical (p. 33).

Yet, despite these notions of mutuality that abound in postmodernist modalities, positivistic assumptions continue to refute reciprocity and intersubjectivity in favour of the 'verifiability principle'. Broadly speaking, this guideline endorses the search for an external reality, privileging empiricist concerns and operational definitions. Indeed these components are thought to encapsulate 'the gold standard' of clinical practice. Consequently, the scientist-practitioner model which endorses these values is committed to scholarship, clinical praxis, and the integration of science and practice (Long & Hollin, 1997). This contrasts with the sociologist thrust that characterizes the findings of this study. Thus although this research identifies and celebrates concepts such as relational depth and mutuality, the dominant discourse of empirical studies continue to repudiate these constructivist processes. For instance, despite empirical evidence marginalizing modality effects on client outcome, numerous researchers such as Siev & Chambless (2007) who reflect a realist rationalist thrust maintain specific treatments are primarily responsible for effective therapy and client change (Duncan, 2002). Nonetheless, notwithstanding these reservations, the mutuality of client/therapist meetings is gradually being recognized. However, in examining the influence of this notion, the next stage of this commentary clarifies its effect.

Effect of Mutuality

Within the realm of psychoanalytic psychotherapy, Ogden (2004) refers to the effect of client/therapist mutuality as 'the analytic third' by stating that, as these individuals live in independent subjective worlds, aspects of their individual interiorities fuse within the therapeutic encounter. Ogden claims this merger creates a third entity that consists of allusions, sensations, and fantasies. Accordingly, these co-mingle as their subjectivities interact. Thus, each member of the dyad brings elements of past relationships, memories, and fantasies to the present relationship.

Regardless of minor differences, Ogden's (2004) notion of the analytic third corresponds with Atwood and Stolorow's (1984) intersubjectivity and Jordan's (1995) relational cultural theory. The latter embodies a feminist psychotherapy that postulates one is both affecting the other and being affected by the other within the therapeutic dyad. This indicates both parties extend receptivity and active initiative that result in a duality of expanding participation, empathy, and concern. Paradoxically, this results in "a transcendence of the experience of a separate self to a larger relational unit" (p. 57) that is profoundly healing.

In critiquing this study's contribution to the domain of psychotherapy, the sub-theme of mutuality constitutes an emergent finding that has significant implications. Essentially, it extends the notion of mutuality, also referred to as intersubjectivity, as an informant of effective psychotherapy. Moreover this notion and the criteria that characterize it are identified and applied to a variety of depth modalities. Additionally, although these processes are recognized by different modalities, this study consolidates these elements into a singular pantheoretical construct with broad application to all therapeutic environments that seek second-order change. In terms of the criteria that characterize pantheoretical mutuality, considerations by Mearns and Cooper (2005) that elaborate on the meaning of mutuality are instructive. These include: i) cognitive-emotional responsiveness to the subjectivity of the other through empathic engagement; ii) a willingness to reveal one's inner states to the other that discloses needs, thoughts, and feelings; iii) the capacity to acknowledge one's needs without manipulating the other to gain personal gratification; iv) valuing the process of knowing, respecting, and enhancing the growth of the other and v) establishing an interacting pattern in which both people are open to change in the interaction.

In arguing this pantheoretical notion consolidates varied types of mutuality that aim for second-order change, this commentary points to diverse theorists and modalities that espouse similar ideas regarding this process. For instance, the humanist-relational theorists, Mearns and Cooper (2005), postulate client and therapist experience mutuality as an

"interpenetration of minds" (p. 46). Although this process contributes to effective therapy, they posit it is impossible to disentangle who feels what towards whom within the dyad. Consequently, they assert the interpersonal processes of co-transparency, co-acceptance and co-receiving induce change.

Correspondingly, Stern's (2004) psychoanalytic research on infant development describes mutuality as a liminal meeting of a "mutual interpenetration of minds (p. 64)". Indeed Stern posits therapist and client know and feel the other's experience. Accordingly, they enter a shared state of intersubjective consciousness akin to Ogden's (2004) analytic third. This state impacts on both therapist and client in ways that resemble Mearns and Cooper's "interpenetration (p. 48)" and Stern's "mutual interpenetration of minds (p. 22)". Moreover Atwood and Stolorow (1984) refer to this intersubjective matrix as "indissoluble psychological system (p. 62)" and "codetermination" (1992, p. 24). Moreover Jordan's (1995, p. 52) "transcendence" captures the essence of this mutuality that privileges growth relatedness.

Finally, this study's findings are significant as they counter the techne model that maintains its stranglehold on psychotherapeutic praxis through precepts such as evidence based practice. This approach suggests diagnosis and classification are positioned at the very heart of the medical model. Consequently, therapist 'objective' assessment of client 'illness' has implications for interventions flowing from this ethos (Kihlstrom, 2002). However, this study's theme of mutuality defies this neutral stance by evidencing that client/therapist intersubjectivity, codetermination, and interpenetration of action, contribute to effective psychotherapy. As indicated, moments of meeting between client and therapist are also identified as components of relational depth. Accordingly, these events are acknowledged as second sub-theme of the overarching theme of relational depth.

Sub-Theme 1.2: Moments of Meeting

At least six of the participants identify specific events within the therapeutic encounter they considered crucial informants of change. These events are viewed as turning points that enhance client/therapist relatedness and outcome effects. Clinical vignettes and informant statements depict these instances as powerful moments of synergetic connection evidenced in words, eye contact, visceral feelings, body movements, or silence. These turning points are described as authentic person-to-person encounters that enhance each party's sense of themselves. Essentially, these are valued as intersubjective moments that stimulate the change process and effective therapy.

Research Excerpts

To do effective therapy there has to be a meeting...I meet the client and they meet me. We take off our masks we're real with each other and this is very liberating because we're both present. I'm plugged in to what is happening in the room... aware of my visceral sensations.... the silences and sighs a strong sense of really being with myself and the client... And if there's no meeting, I want to know why. I want to know how I've missed and how they've missed me....or if this is part of what they've brought to therapy.

This passage captures the intersubjective contact that occurs in a typical therapeutic meeting. Although this excerpt is short, it attests to relatedness that typifies these moments. Essentially, it reveals the attunement, presence, and receptivity that occur. Moreover, it reflects the sense of aliveness and 'here and now' momentum that characterize these occurrences. Its liminal nature is explored in the passage that follows:

There are certain moments in therapy when the client contacts a part of themselves that is new to them... It usually comes through our connection and these liminal moments are usually fresh and deeply significant ...They seem to touch something that's at the core of therapy ... It's always very moving...for few moments we share a kind of oneness... I really can't really describe it... It's as if our souls share the same space... and a kind of

timelessness and stillness descends. Sometimes I feel it will break my chest wide open.

Whilst the first passage highlights physical, visceral sensations of moments of meeting, this second passage emphasizes reciprocity that manifests with affective sensations that occur within the therapist. In particular, the latter brings a spiritual dimension implicit in the use of phrases such as “our souls share the same space... oneness....a kind of timelessness and stillness”. However the third excerpt that follows brings a pragmatic sensibility to moments of meeting that contrasts in tone with the prior examples. This highlights therapist attempts to meet the needs of clients through all available resources. Although it focuses on the role of the therapists, it demonstrates that making contact is an essential requirement of the therapeutic endeavour.

If a client's feeling something... anger... irritation or whatever I try as much as I can to get a sense of what it is... and communicate it to them. Hopefully... at some level they feel met... Or at least they know I'm trying to be with them... Sometimes it's by mirroring ... or simply asking "How did you feel?" Sometimes it's non-verbal...I'll just sit with them because ...they don't know the words ... and I don't know the words...so then I might say "Is it like this?" or "Have you got a picture for it or a colour for it?"

Discussion: Therapeutic Turning Points

This study affirms previous research that identifies the existence of specific moments in psychotherapy that function as turning points in the change process. Furthermore, these events are believed to contribute to therapeutic effectiveness. Although it is suggested that moments of meeting are an attribute of relational depth (Mearns & Cooper, 2005), they are also found in a variety of therapeutic frameworks (Cissna & Anderson, 2002). For instance, existentialists and humanists such as Buber (1958) and Hycner (1991) describe this phenomenon as I-Thou meetings or dialogic moments. Alternatively, Stern (2004) espouses a psychoanalytic perspective that views moments of meeting as “mutual interpenetration of minds” (p. 20). Lyons-Ruth (1998), articulating a psychodynamic perspective, posits

these are 'special moments' of authentic person-to-person connection between that alter relating as well as the client's sense of themselves.

In effect, these theories share a common thrust: they view moments of meeting as 'ways-of-being with-another' based on the sharing of experience. Moreover, this form of intersubjectivity is potentially transformative. Indeed Stern (2004) describes this encounter as a relational meeting that enables client and therapist to share their mental landscapes. As part of this process, parties engage in a deepening relational dynamic termed 'moving along'. Through this dynamic the parties sense their direction yet do not know when and how they will take the necessary steps towards an uncertain therapeutic goal. Stern refers to these momentary steps as 'present moments' stating they are informed by the desire to find answers to internalized, present-oriented questions. These include reflections such as what is happening here and now between us? What do I sense about how you experience me now and what do you know about how I experience you now (Stern, 2004, p. 120)? However in the midst of this uncertainty, a spontaneous affectively charged 'hot' moment arises. Stern (1998) coins this phenomenon a 'now moment' that challenges existing relational patterns. Accordingly, this creates tensions between the parties. Nonetheless, when client and therapist seize this de-stabilizing moment and meet it authentically, a new event coined a 'moment of meeting' arises. Hence, a new intersubjective state manifests that has the effect of changing each of the parties.

Stern (2004, p. 233) refers to this phenomenon as a "shared feeling voyage" comprised of present moments, now moments, and moments of meeting. The complexity of these interrelated notions is summarized by Stern as "a world in a grain of sand" (p. 371). Accordingly, these minutiae multiply as relational interactions deepen. These influences direct clients to embrace change in an evolving dynamic of effective psychotherapy. In reviewing these significant moments of contact, Gotthold and Sorter (2006) point out 'present moments', 'now moments', and 'moments of meeting' represent diverse units of implicit relational knowing. As this notion

embodies an important interpersonal process its major features are explored below.

Implicit Relational Knowing

For the most part, as this kind of knowing is learned, over time it becomes automatic. Moreover, as implicit relational knowing is usually enacted without conscious thought, it may never require symbolic encoding. Indeed, the Boston Process of Change Study Group that conducts research into the dynamics of psychotherapeutic change has dramatically extended procedural knowledge to mean “how we do things with others” (Gotthold & Sorter, 2006, p. 104). This refers to interactive ways of being together that stem from co-constructive processes. These commence with interactions between infant and caregiver that are procedurally encoded before the development of symbolic language. Indeed, Lyons-Ruth (1998) notes that “implicit relational knowing encompasses normal and pathological knowing and integrates affect, fantasy, behavioral and cognitive dimensions” (p. 285). In addition, implicit relational knowing transforms gradually as it becomes “more articulated, integrated and complex, since it is being transformed, updated and ‘recognized’ in every day interactions (p. 285).

As this study determines that moments of meeting occurring within the context of psychotherapy are change events guided by procedural knowing, they fall within the scope of Polkinghorne’s (2004) practice wisdom. As indicated in earlier chapters of this thesis, this form of decision-making derives from a domain distinguishable from the rationalist pragmatism of *techne*. This alternative discourse posits that actions by psychotherapeutic practitioners stem from situational-driven judgments that respond to the demands of interpersonal interaction. Accordingly, this approach highlights the importance of interventions determined by context-driven, implicit therapist acumen. However, although this position has relevance to psychotherapeutic praxis, its tenets are at odds with positivistic *techne* objectivism that privileges empirically validated treatments as the sole source of effective psychotherapy.

Furthermore, this form of applied praxis exemplifies Polanyi's (1966) notions of tacit knowing. This constitutes expertise, skill, and 'know how' acquired with limited conscious awareness. In essence, practice wisdom is viewed as personal, context-specific and deeply rooted in experience, emotion, values and ideas. Thus implicit knowing is brought to the therapeutic encounter to enhance the ongoing unfolding of co-constructed, mutually regulated dyadic experiences. Ultimately, this emerges from the intersubjective crossing of client and therapist through the process of implicit relational knowing. Likewise, as with Polkinghorne's (2004) practice wisdom, Polanyi's tacit knowledge is antithetical to empirically knowledge as the former is a context-driven, process-in-action resource rather than an end product. Thus, implicit relational knowing is difficult to tap when compared with declarative, propositional knowledge. This is so internalized within individual that it becomes a natural part of behaviour or way of thinking.

Finally, moments of meeting typify interventions that derive from Dewey's (1933) and Schön's (1987) notions of reflective understanding. These constructs acknowledge out of awareness, non-conscious processes determine most features of therapeutic praxis. In particular, reflective understanding draws on internalized practitioner knowledge to realise therapeutic goals. Essentially, this embodies an active process of decision-making that adds to background knowledge. Indeed, practitioner reflective-understanding constitutes a dialogic engagement with a specific situation that leads to the enactment of a number of practices. These actions bring increased knowledge of a situation as it unfolds (Polkinghorne, 2004, p. 163). Consequently, this is not amenable to controlled random testing or any of the other form of empirical assessment because of its tacit flavour.

Moments of meeting are aspects of reflective understanding that emerge in practice due to deficits in propositional, declarative knowledge. Schön (1983) makes the point that individuals engage in reflective practice when background informed practices are insufficient to achieve specific goals. The latter constitute pre-theoretical knowledge that supports individuals in decision-making. Dewey (1933), who originated this notion,

argues human beings experience the world through an interactive process that is always contextualized. With this in mind, Schön (1983) postulates that when background ideas fail to satisfy practitioners, the phenomenon of reflection occurs. Specifically, this takes two forms: reflection-in-action and reflection-on-action. Reflection-in-action occurs when individuals 'think on their feet' by taking account of their experiences, feelings and theories. Reflection-on-action arises after an encounter when practitioners who facilitated the activity have an opportunity to explore it after the event. In doing so, they develop sets of questions and ideas about their activities and practice. Once again, Schön (1983) posits both forms of reflection are procedural and context specific. Thus, as traditional positivistic research methods cannot investigate these moments of meeting this has implications for the advancement of psychotherapeutic knowledge discussed later in this chapter.

Sub-Theme 1.3: Relational Presence

The sub-theme of relational presence indicates both client and therapist contribute full attendance to relating, enhanced by their mutual quality of mind. Moreover the findings of this study determine that when therapist and client experience relational presence, this enhances the effectiveness of psychotherapy. Although this notion is explored by a variety of research and commentaries, it is generally assumed to be a quality of engagement brought by therapists alone. However this study contends presence is an interpersonal process that both parties to the therapeutic encounter.

Research Excerpts

It's a two-way process.....you can talk about empathy and congruencebut it boils down to one thing...the therapist has to be fully engaged and the client has to be fully engaged...It starts with the therapist's ability to be there ...But to do this therapists have to empty themselves and clear a space inside so they can truly show up for the session... Then the encounter becomes an authentic moment... of attending to... and experiencingknowing the other is also encountering the experience.

This first excerpt reveals something of its complexity and multi-dimensional nature. References to the duality and synchronicity of this shared experience are notable. Clearly, the level of mutual engagement is considered vital to this experience.

The second excerpt that follows highlights the immersion required of relational presence:

When I'm present nothing else exists... the patient's experience and my response is all there is.... I'm fully immersedEngaged in the moment.... It's a reciprocal thing for the client as well.....a liminal space...where there's no separation...I'm completely absorbed in what happens and they're completely absorbed as well It's as if I'm taken over by a kind of inner spaciousness. At the same time I feel connected to something outside the space that's supporting what's happening in the session. And this enhances my focus... so everything I feel is intensified. It's like we're in a bubble.

This vignette also infers the multiple features that typify therapeutic presence. Whilst this description and the one that follows are far more visceral and body-oriented than the first scenario, it also emphasizes the level of engagement required.

I asked her the first time she came how she felt about coming and then I asked her the same thing the second time she came. The first time I could barely ground myself....I was aware of her incredibly high levels of anxiety. I knew I was plugging into it... It was overpowering but I could observe internally. And this gave me evidence that she felt it was not okay to comethat she was very frightened. Also I knew not to challenge her about it until the second time I saw her. I knew if I asked her the first time she wouldn't be able to bear it ...It was too confronting...It was more than enough for her to just be here.... for the first time.

Although all three examples of relational presence refer to the momentary nature of this engagement, the second and third excerpts are more mystical and expansive than the first. Moreover the latter passages demonstrate the close attention, commitment, and receptivity that

therapists bring to the encounter and their capacity to tune in to the affective state of the client. Although these passages differ in quality and content they convey the various levels of relational presence.

Discussion: Mutuality of Presence

The linguistic origin of the word 'presence' denotes something of its current meaning and its relevance to the findings of this study. The word is derived from the Latin 'praesentia' meaning "to be present before others" (Flexner, 1987). Moreover the French word 'praesentare' means to place before, to hold out or to offer. Thus these meanings collectively suggest the offering of one's being is central to the meaning of presence. Although the majority of psychotherapeutic authorities concede the therapist's presence fulfills an important function in the therapeutic alliance, they are more reticent about its application to clients (Geller & Greenberg, 2002).

Although the reciprocal nature of therapeutic presence is not clearly articulated in the literature, this study determined it is characterized by client/therapist mutuality and shared investment in the strength of the therapeutic relationship. Additionally, the depth and integrity of relational presence is said to have an impact on client outcomes. Support for this stance stems from Bugental's (1999) reflections that posit therapeutic presence embodies a quality of being-in- relationship assumed by both client and therapist. Consequently, this interpersonal stance demonstrates the intention of both parties to participate in an encounter with one another as fully as possible. In describing the mutuality of this process, Bracke and Bugental (2004) argue that clients manifest a degree of presence through sensitivity to self and other. Accordingly, this instigates the capacity of therapists to respond to clients in kind. Thus, to be effective, therapists are required to manifest sensitivity in assessing client genuineness in their commitment to pursue increased immersion in therapeutic work. Moreover, Bracke and Bugental posit client authentic involvement and reciprocal responses of therapists proves critical in determining client outcomes. In other words, these theorists claim the success of therapy is directly attributable to the level of relational presence operating within the therapeutic relationship. However, as indicated, this

relational aspect of presence that includes both therapist and client has only limited acceptance. Although Bracke and Bugental represent humanist views of psychotherapy, their response to the mutuality of presence is not adopted by other modalities. Indeed the majority of studies investigate the notion of presence based on the phenomenological experience of psychotherapists. Research by Geller and Greenberg (2002) is the most notable of these attempts.

Geller and Greenberg (2002) undertook a series of in-depth qualitative interviews with seven experts from a range of orientations that focus on their subjective understandings of therapeutic presence. When these informants were asked to reflect on this notion, they described the multi-dimensional levels of personal response demanded by therapeutic presence. Initially, they stressed their responsibility to ensure that clients feel seen, heard, and understood. This brought attention to their capacity to be fully receptive to client bodily, emotional, and cognitive needs. Informants also affirmed their need to attend to their own spontaneous, intuitive responses whilst extending themselves to clients in congruent ways. Thus they stressed therapists were required to function at multiple levels of awareness to ensure they maintained contact with client experience, their own response as well as occurrences in the space in-between these parties. Moreover, although therapist openness to the moment involved sensitivity to the details of these experiences, informants also remarked that when they were present they were aware they were in touch with a larger state of expansiveness that transcended themselves, the client, and the therapeutic encounter. However, although these informants described the attributes of presence experienced by therapists they also referred to the mutuality of this construct. In particular they stressed their view that therapeutic presence embodies an interpersonal process. In particular, they considered the experience of therapeutic presence necessitated joint immersion and absorption by therapist and client in the present moment.

Although Geller and Greenberg's (2002) findings view presence as a therapist quality, they do make reference to the existence of deep

relational contact between the parties. Thus it is respectfully suggested that, in view of this dyadic duality and reciprocity, therapeutic presence is more likely to be perceived as a relational construct characterized by mutuality rather than a one-dimensional process experienced by the therapist alone.

This argument is enhanced by the reflections of Schmid (2001) who asserts that therapeutic presence is directed to being with clients rather than doing to clients. This implies that both client and therapist are open and receptive to one another's experience. Yet, although this interpretation of relational presence is in keeping with the findings of this study, the importance of presence as a therapist attribute cannot be denied. Indeed, perhaps the most significant theoretical argument that endorses the importance of presence is presented by Rogers (1986). Shortly before his death, he reflected on his conceptualisation of the three core conditions necessary for therapeutic change. In a number of conversations he spoke of the need for a fourth condition of equal merit, widely believed to be therapeutic presence (Thorne, 1991).

Additionally Bugental (1999) has developed a five level taxonomy that enables therapists to assess the level of client presence before determining the appropriateness of their therapeutic treatment. This construct is prefaced on the understanding that clients bring their accessibility and expressiveness to the therapeutic encounter. Accessibility refers to the extent to which clients are willing to let their defenses down whilst expressiveness relates to client ability to disclose inner experiencing. As individuals vary tremendously in their capacity to be accessible and expressive, Bugental's assessment guide ascertains client functioning in this regard. This aims to determine the necessary level of client/therapist immersion required to produce life-changing therapy. Thus on the basis of prior research the question of relational presence remains oblique and equivocal.

In summary, this study extends the notion of therapeutic presence to apply to both therapist and client in a reciprocal circle of mutuality. Although studies have limited presence to an attribute of therapists, this

has been extended to clients in a few cases. Whilst Bracke and Bugental (2002) fall within this category, their comments reflect humanist approaches. However as this study represents a cross-section of depth therapies, it is argued that therapeutic presence is a transtheoretical process that speaks to joint therapist and client immersion. Moreover the reflections of Geller and Greenberg (2002) make this argument more likely. The implications of this determination are discussed later in this chapter.

Sub-Theme 1.4: Therapist/Client Realness

A further sub-theme of the study establishes that client and therapist realness is a component of relational depth that contributes to the strength and integrity of the therapeutic relationship. Accordingly, this component impacts on client change. The extracts that follow demonstrate the effect of realness.

Research Excerpts

I try to be authenticand so does the client. Each of us is in touch with their experience. But even though I reveal myself in an intimate way I don't disclose the personal details of my life. In fact what happens is much more meaningful...I reveal my inner being to the client...and they reveal their inner being to me...as much as they can...and this is deeply personal. And often this means, like the client, I'm in touch with my own vulnerabilities.

This passage reveals the reciprocal nature of the therapeutic encounter and the duality of processes that impact on psychotherapeutic success. Unlike the scientism of the medical model, the humanness of this encounter is stressed. The informant adopts language that is deeply personal and revealing. This parallels the internal states of individuals who participate in the interpersonal process of therapeutic meeting. This theme is explored further in the second example of relational realness that follows. This refers to the 'as if' relationship that underpins the working alliance. Although this does not qualify as real relationship, it adopts many of the features of genuine relatedness such as transparency and openness even through this is restricted by appropriate boundaries.

When therapy works it's a real encounter. I'm there meeting another person in a very transparent way. It's an 'as if' meeting rather than a real life relationship, but there's a realness in our relating. Clients know me from how I present myself but they don't know me in terms of the facts of my life. Yet, paradoxically, they really do come to "know" me and I come to "know" them in an authentic way.

Finally, as the passage that follows describes a clinical event, the meaning of a 'real' encounter is revealed. Specifically it demonstrates therapist determination to ascertain the reality of the client responses, despite their defenses. This reciprocity manifests as the therapist works with the authenticity of the therapeutic relationship to unleash client responses. Essentially, the therapist's search for genuineness enables the client to become more open to her own experiencing.

The thing that comes up is a client who I have seen for a long time. Maybe five years or so....She's got very major issues of annihilation and invisibility... and these were evoked recently when she came to see me in new rooms that are very visible to the public. The work we did concerned my refusal to go along with her saying that the change of venue hadn't bothered her. Instead of accepting her statement that things were fine... I gently asked her how it felt to come here for the first time....and if anything was wrong about it. I knew the work involved getting her to admit that it was terrible for her... That it was terrible for her to come and go for fear of being seen.... that it was terrible to find the waiting room and decide where she should sit... and it was terrible to find where the toilet was. But it was better for her to actually speak about how bad it really was to come rather than being "okay". It wasn't like a particularly profound thing... but it was for her at a deeper level to have someone actually see and notice ...not buy into her stance of Yep she's fine... she can manage....So as I persisted she finally let go...she could admit how she really felt....and it got her in touch with the rage and anger of her life...that she could never admit to before.

Discussion: Mutuality of Realness

All participants in the second phase of the study allude to their belief they considered authenticity, genuineness, and congruence as features of the relationship that enhance therapeutic success. When asked to expand on the meaning of these notions the majority cite the realness of connection between therapist and client as the simplest ways to describe these features. These understandings affirm informed commentary that posits therapist/client realness is a crucial feature of relational depth that signals the presence of effective psychotherapy (Mearns & Cooper, 2005). Although the attribute of realness is primarily associated with Roger's (1961) client centred therapy, it is suggested that realness is a transtheoretical feature, inherent all effective therapeutic relationships. In explaining the meaning of realness Goldman (1993) postulates the following:

The notion of the real is about being alive, creative, spontaneous, and playful; cherishing one's uniqueness, accepting one's insignificance, tolerating one's destructive impulses, living with one's own insanity; feeling integrated while retaining the capacity for unintegration (p. xvii).

In a less complex conceptualization Rogers et al. (1967, p. 100) submit realness is about the therapist "being the feelings and attitudes that are at the moment flowing within him". Norcross (2002) adds to this explication by stating when therapists are real they do not hide behind their professional role or hold back obvious feelings. Moreover, Norcross acknowledges realness corresponds with the Rogerian condition of congruence more closely than any other therapist quality. This is based on Roger's ideas about congruence and realness and the relevance of these notions to therapy.

Rogers et al. (1967) define the problems clients bring to therapy in terms of their incongruence and view the therapy process as helping clients to own and express feelings without fear. Thus therapist congruence serves as a model to the client as the realness of the therapist enables client to

become more open to their own experiencing. Accordingly, this makes the therapist/client relationship deeper and the psychological contact between these parties more immediate.

Another take on realness is advanced by Jordan's (1991) relational-cultural theory. This view posits realness is "a willingness and ability to reveal one's own inner states to the other person, to make one's needs known, to share one's thoughts and feelings, giving access to one's subjective world" (p. 82). Although this explains this notion in more detail than Roger's (1961) exposition of congruence, the mutual, reciprocal effects of both processes are apparent. Moreover a study by McMillan and McLeod (2006) adds to this understanding by finding that clients are willing to 'let go' when they are engaged in a real therapeutic relationship. Knox (2008) posits clients feel 'real' when they perceive therapists as real persons whilst Portnoy (1999) claims moments of real and genuine meeting make psychotherapy work. Nevertheless, in view of the importance of relational realness a question remains with regard to the 'as if' relationship. As this is referred to in the second research excerpt, it requires further explication.

Paradox of the 'As If' Relationship

The paramount question, implicit in the 'as if' construct, questions whether the notions of relational realness and the 'as if' relationship are antithetical. Alternatively the existence of this notion asks whether they co-exist with one another as a paradoxical duality. Although Whelan (1992) describes the therapeutic relationship as an 'as-if' relationship' to differentiate this concept from 'real' relationships constructed in everyday life, this does not make the therapeutic connection any less real. In fact, it highlights the diversity of relatedness that manifests within this encounter. This variation is well-illustrated by Clarkson's (1998) notion of five primary universes of discourse. This identifies five different forms of relatedness within the therapeutic endeavour that include the working alliance, the transference and countertransference relationship, the developmental/reparative relationship, the person-to-person/real relationship, and the transpersonal relationship. Accordingly, therapists

undertake a process of analyzing, identifying and naming different qualities embedded in the therapeutic relationship in the light of these universes of discourse. Indeed Clarkson's model is enlightening as it contextualises Whelan's 'as if' description as only one aspect of a complex multi-layered phenomenon. Accordingly, the realness and authenticity of the therapeutic relationship within the meaning of this discussion fits within the person-to-person domain of Clarkson's model. Jacobs (2004) contends this is a real relationship that exists simply by virtue of the fact that two or more people have come together; one in the role of helper and the other one seeking help.

Whatever else divides them, they are ordinary human beings, sharing in the common joys and sorrows of life, although their individual circumstances may mean different joys and sorrows (p. 124).

Sub-Theme 1.5: Client/Therapist Receptivity

The findings of the study identify client/therapist receptivity as a sub-theme of relational depth. Accordingly, this component is acknowledged as an interpersonal process that makes therapy work. In exploring the features of receptivity, the first excerpt that follows highlights the parties' openness to visceral and physical exchanges.

Research Excerpts

The client becomes naked. They strip off their defenses and respond ...and sometimes it's difficult because they're challenged by their nakedness. But as they let down their walls...probably for one of the few times in their lives...they let themselves remain open. And I think this happens when they know I'm really open to them... in a very visceral way... they know I understand what they're feeling. And they let me in gradually...so they can take things in...at a sensory level And they realise I'm as moved as they are.

In this passage the metaphor of nakedness emphasizes the availability of client and therapist in a very obvious manner. However, although the dropping of client defenses is alluded to, it is expanded on in passage that follows.

The space between us has to be very open and very safe for both of us...in that the client learns to trust me and I learn to trust them...so that she can say things they don't need to defend against...So...its trusting and safe...Like a space with a very clear light in the middle of a very dark cave...The cave is surrounded by heavy rock but the light where we work is very clear. I'm thinking of a woman I saw today....the scenario explains what I mean. We were talking about her family's emotional dynamics around money. I experienced what she described as very controlling. In contrast she experienced what she was describing as very sad...because in this system she has to really watch her back. So here are two very different subjective experiences towards the same situation...So we work with it by being quite open...I said I felt alarmed because she felt really sad about having to protect herself...and she put in things about her experience she felt without feeling she had to see it my way...it was important to hold both those things as true. And we work with that...so they could co-exist...and she could deal with the differences in our perspectives without feeling controlled.

This second excerpt highlights the mutuality of both members of the dyad in accepting the different positions each holds, whilst remaining accessible to working freely with the other. The metaphor of the clear light in the midst of the dark cave captures the sensitivity required by both parties to navigate this delicate path of reciprocal of receptivity. The third excerpt that follows expands on the qualities of availability and accessibility, intrinsic to receptivity and the difficult challenge this poses for clients. The use of language such as 'barriers' and 'suffering' highlights the nature of this task.

There must be a readiness in the client to face the unknown. And of course this is the greatest fear. It's why clients cling to their suffering - they know it... they've used to it...and they've survived it... their story has become a habit.....and this makes it very difficult to take anything else in.....The thought of saying 'yes' to a new story is terrifying. Yet slowly... over time... as their trust builds... the barriers fall away...but sometimes it can take years.

Discussion: Clarifying Receptivity

Diverse therapeutic modalities reflect similar views regarding therapist/client receptivity and its impact on effective therapy and client change. For instance, relational cultural theory (Jordan, 1995), intersubjective psychotherapy (Stolorow & Atwood, 1993), and humanist approaches (Cooper, 2005) highlight the impact of mutual receptivity. All these modalities determine that both client and therapist are mutually receptive to multisensory encounters that deepen their relational contact. Accordingly, this dynamic enhances the therapeutic relationship that makes therapy work. This reciprocal interpersonal process ensures client and therapist remain open and available to the other, allowing the effects of their encounter to flow to and from each dyad member. Jordan refers to the impact of reciprocity as “expanding participation, engagement and openness” (p. 56). Similarly, Geller and Greenberg (2002) as client centred therapists, assert that receptivity demands a conscious commitment by both therapist and client to experience all dimensions of the therapeutic experience. Moreover, they make the point this contrasts with observation from a clinical distance.

Although empirical research is limited, informed commentary from divergent perspectives express similar views regarding the notion of receptivity. The literature contends therapists ‘listen’ deeply to their clients, transcending the limitations of language with their ‘third ear’ (Reik, 1948). Tronick (2005, p. 294) describes this reciprocal receptivity as “dyadically expanded state of consciousness” in which both therapist and client meet to share a sacred space (Geller & Greenberg, 2002). Turner (1967, p. 94 describes liminality as a transitional space where both parties are “betwixt and between”. Johnson (2005) contends during liminal moments clients become receptive to multiple sensations that are not within their range of normal experience. Anderson (2005) argues liminality causes clients to become disoriented so that differences in status and knowledge are temporarily dissolved. Instead, a sense of mutuality informs the relating of both parties that transforms experience by creating enhanced self-views and new perspectives on problems.

Summary of Relational Depth and its Attributes

Essentially, the findings of this study ascertain the overarching theme of relational depth and its component sub-themes of mutuality, moments of meeting, relational presence, realness and receptivity are interpersonal processes that make psychotherapy work. Accordingly, these dynamics create an environment of openness and trust that enables therapists to work with clients in dialogical way. This infers that therapists bring themselves fully into the encounter so they may connect with clients in a mutual and transparent way. Although this approach does not abrogate the science-practitioner model, it does question the dominance of the medical model in its privileging of *techne* (Polkinghorne, 2004).

Instead, the findings of this research suggest therapy is effective when clients and therapists operate at real and genuine levels. In effect, the essence of this interpersonal encounter demonstrates “the client is being real in relation to the therapist being real” (Mearns & Copper, 2005, p. 9). Although this conceptualizes the crux of the healing process it does not de-construct the importance of other relational variables. For instance in 2002 the Steering Committee of the American Psychological Association (APA) set up a Task Force to review all the available data on the link between the therapeutic relationship and therapeutic outcomes. Its principal findings determined the therapy relationship made substantive contributions to outcomes irrespective of the type of therapy applied. Specifically, the Steering Committee identified seven relational variables it found to be promising and effective. These include the positive regard of therapists towards clients; therapist congruence within the therapeutic encounter; feedback by therapists to clients regarding their behaviours; therapist levels of self-disclosure; therapist willingness to repair relationship ruptures; therapist ability to manage countertransference issues, and the quality of relational interpretations provided by therapists based on their working alliance.

Whilst these qualities offer substantive guidance as to the ingredients of client change, there is no suggestion of the reciprocity and mutuality that emerge from this study. Although the relational turn within

psychotherapy occurred prior to the findings of the Steering Committee (2002), there is little reference to this therapeutic mindset. However, it is suggested that as psychotherapy moves towards an intersubjective understanding of human existence, this is likely to encourage the development of a more relational form of therapeutic praxis.

Moreover this investigation of interpersonal events in psychotherapy highlights specific moments that are transformative in therapeutic effect. This 'significant moment' paradigm, initially developed by Elliott (1989), is traditionally used to heighten researcher understandings of specific events or therapy processes. A broad spectrum of themes are examined in interview studies, including client and therapist descriptions of moments of misunderstanding (Rhodes, Hill, Thompson, & Elliott, 1994), insight events (Elliott et al. (1994) helpful events (Paulson, Truscott, & Stuart, 1999), problematic reaction points (Watson & Rennie, 1994), and helpful therapists' interventions (Elliott, James, Reimschuessel, Cislo, & Sack, 1985). Although interpersonal processes that influence effective therapy are explored in this chapter, the study also identifies specific micro-events that occur within the interpersonal environment of therapy that influence its success. Accordingly, these micro-events are collectively referred to as the overarching theme of significant moments in psychotherapy. As these are held to be crucial influences of therapeutic success, the next task of this discussion reviews these moments and some of their components in the light of research and informed commentary.

Overarching Theme 2: Significant Moments and Client Change

Research using outcome measures is criticized as it rarely provides information regarding moment-to-moment process within the psychotherapy session. Moreover, it seldom assesses the meaning of change in the lives of clients (Rennie, 1994). As a result, psychotherapy researchers call for qualitative approaches to inquiry as one path through which researchers can develop understandings of the in-session interpersonal processes of change. They argue these methods focus on subjectivity that is appropriate for understanding therapy. This allows clients and therapists to articulate and contextualize elements of change that appear to be important (McLeod,

2001). As research examining significant psychotherapy moments are forms of implicit procedural knowledge, some discussion of this notion introduces the paradigm of significant moments.

Stern (1998) and indeed many process theorists, argue the mechanisms that bring about change in psychotherapy are incompletely understood. This is due to the fact that much of this mutative action involves the domain of implicit knowledge. This refers to what therapists and clients do, think, and feel in specific relational contexts. Implicit procedural knowledge and knowing is not conscious knowing as it operates out of awareness. Moreover it is as much affective and interactive as it is cognitive. Moreover it depends upon the clinical sensitivity of therapists and their ability to detect multiple meanings encoded in single messages. In addition, implicit knowing, governing intimate interactions are not language-based or routinely translated into semantic form. However, in a therapeutic context, small areas of client implicit relational knowing may become the subject of verbal articulation and/or transference interpretation. However, these areas that become consciously articulated are only a small part of the totality of the client/therapist implicit operating procedures. Thus implicit relational knowing operates largely outside the realm of verbal consciousness and the dynamic unconscious (Lyons-Ruth, 1998). Moreover the micro-processes of therapy sessions occur in an improvisational mode in which small steps required to arrive at a goal are unpredictable. The goal, itself, is not always clear and often shifts without notice. Consequently, during a session, points of mutative potential arise at unpremeditated 'moments.' A moment is conceived of as a short unit of time in which something of importance relating to the future occurs. Such events are viewed as emergent properties of complex, dynamic systems that are nonlinear leaps in the process of a therapy session. Although discussion of these transformational moments are restricted to therapeutic moments and vulnerable moments identified by this study, informed literature suggests significant moments have broader application.

Sub-Theme 2.1: Significant Moments

Relational therapists increasingly focus on individual moments as the place of tangible change in psychotherapy. These are moments when something new is jointly created, built on the interplay of both therapist and client. These are creative growth fostering occasions in which the relationship is propelled in a healing direction leading to “movement-in-representation” (Stiver, Rosen, Surrey & Miller, 2000, p. 1). The clinical vignette that follows demonstrates this therapeutic thrust.

Research Excerpt

In a very important moment the patient was talking about feeling as if he'd shed a skin... but this has to be seen in the context of multiple important moments that occurred throughout the twice weekly sessions we had... for more than one year... He'd come in a profoundly depressed, non-functional state....unable to work or drive.... and crying perpetually. He'd had previous therapy and the therapist felt that he needed intense analysis... so he came along... very committed to the work... and the fit was good enough... and on the basis of a benevolent holding relationship ...I was able to move into the work of containment....And he made a lot of progress. In that first year he returned to work and was able to fly in an airplane which he hadn't done before... and there were quite a lot of substantial changes... both in symptoms and in his intra-psychic world. He had a lot of resources... and I think these enabled him to develop a very muscular second skin over the course of therapy....Although he'd had functioned well in the world with his first skinthere had been a price to pay. It developed as an infant when he became a container for himself because his mother was unavailable... and the skin had worked....up to a point... But by the time he entered therapy the first skin was torn and leaky... it wasn't functioning well. So he was able to shed it through his experience of therapy... in fact the first skin became redundant. He no longer needed it because he had developed a second muscular skin during the course of therapy. And when he realized this it was a special moment amongst many moments. It wasn't like there was suddenly this amazing

experience...it was memorable and poignant... but there were many such moments along the way. In fact when he said he'd reached the point of feeling like he'd shed a skin, it was a testament to the work he'd done over many significant moments. It was the cherry on the cake he'd baked over a long period!

This metaphor of the first and second skin throughout illustrates the importance of incremental moments throughout the course of therapy. These are process-driven subtle changes in the therapeutic environment that advance therapy and client change. Although the informant alludes to a poignant moment when the client realized he could discard his 'redundant' 'leaky' skin, she makes the point that this was one of many similar moments that contributed to this recognition. Moreover there is an implied inference that therapy was effective due to its relational features. Specifically, the containment by the therapist and client resources appear to be the primary informants of change.

Discussion: Context of Significant Moments

This example cited demonstrates that moments of change are built on what has come before, initiated by either therapist or client. Elliott (1986) posits the essence of this action depends on both parties moving forward towards a new experience of connection in the present. Dryden (2002) contends in such moments both client and therapist move towards a deeper connection with self, other, and the relational flow. They may be very simple moments when a spontaneous opening takes the relationship to a new place through a smile, a mutual gaze, or a pause in saying goodbye. Levitt et al. (2006) postulate that as the relationship develops it enlarges and grows in spaciousness, aliveness, freedom, spontaneity, resilience, and creative power. The intentional direction of change remains focused on client growth, but both parties are moved by the momentum of the new connection. Surrey (2005) makes the point that although there are numerous forms of these significant moments, some are particularly healing in their quality. According to Surrey these are very alive moments of healing that reflect relational connection and mutual presence that emerge from all the relational moments that have come before. Indeed Jordan (2009)

contends when a connected relational moment arises it expresses the microcosm of the whole relationship as its texture is built on shared experiences and understanding. As these significant moments are characterized by a plethora of diverse conceptualizations that range from Stern's (2004) 'present moments', 'now moments' and 'moments of meeting', Buber's (1970) dialogic moments and Jordan's (1997) moments of connection, this study focuses on therapeutic moments and vulnerable moments that are identified in this research.

Sub-Theme 2.2: Therapeutic Moments, Client Change and Effective Therapy

All informants identify specific moments in psychotherapy that are therapeutic in effect. These instances are viewed as an important sub-theme of this study within the broader overarching theme of significant moments. Specifically, therapeutic moments are identified as curative responses within the intersubjective field that transcend verbal effects. Accordingly, they are classed as important informants of effective therapy and client development. Essentially, the shared implicit relationship between client and therapist reflects the evolving sense in client and therapist of who the other is, who each is to the other and who they are together. Consequently the excerpts that follow reveal the features of therapeutic moments.

Research Excerpts

It's a moment of affective and cognitive connection. It might be when the patient suddenly understands something. It can be very illuminating but unsettling as well. I call it a moment of truth and beauty because it has an aesthetic quality....like a new consciousness... with a valence for actual beauty... Finding beauty in something they didn't find the beauty in before... a particular food or beautiful flower ...a particular piece of music.... But the affective state is carried beyond the moment. You can still sense it long after it has occurred. It's usually around something unbearable for the patient that's being experienced in me as well.

Although this first excerpt does not depict the inherent mechanisms of a change event, it describes affective and cognitive shifts signaling a significant therapeutic event. This may include a heightened 'feeling state' over a number of sessions or an enhanced subjective experience that brings new insight.

In contrast, the second excerpt that follows captures transformational changes that emerged in a therapeutic moment. While this passage does not describe an exact instant, it alludes to a series of intersubjective moments as agents of change. In this excerpt, the intersubjective sharing stems from a genuine therapeutic mistake. Accordingly this affects the relatedness of both parties as they engage in a 'hot' therapeutic moment that threatens the stability of the working alliance. However the authenticity of relating and mutual sharing lead the client to a series of life changing realizations that extends far beyond the session.

A patient who I've been seeing for some time told me about a recent court appearance he managed well. He was pleased with himself so I complimented him on his success - and I recall being quite effusive in my response. When I finished he turned around and said "Well, thanks for the sermon. What's next week's lesson going to be about? Do you think I am stupid or something? You're just like my mother...you go on at me just like she did!" I was shocked but we'd come to the end of the session so I said: "Well, it seems that what has been evoked in you is very significant. I think it's going to be pretty important for us to try and understand what's happening.... next time". He said "Well that's good and go and tell all the other women in the world to do the same" and off he went. When he came back we explored his reaction. He said he was overwhelmed by my comments and felt stupid in my eyes. I explained that I admired the way he handled himself in court and that it didn't cross my mind that he was stupid. He responded in a very surprised manner and looked and looked at me. Then he started to free associate...and a whole lot of experiences of feeling stupid came to mind that revealed how inferior he felt in relation to people he perceived to be superior. Then he sat back in the couch, put

his head back and tears started rolling down his face." I just can't bear it if anybody behaves like a mother to me. It feels like all that my mother ever said was ... "you're stupid...you don't know". And then he started to sob... And I felt like sobbing because the moment was so moving. Then he said quietly "I've bumped a whole lot of people out of my life because if anyone says anything complementary to me I think they're telling me I'm stupid". So he came back and engaged with this moment for three subsequent sessions and explored how many people he had rejected in his life because he felt they thought he was stupid. He understood now that they were really saying they cared about him. He now knew why he chose partners who were non-validating. In the third session, he reflected on a recent experience of someone who had remarked "We really must see more of you ...you're such an, interesting man"! He said he felt chuffed and admitted "I don't think I would have been able to take that comment in the past. I would have thought "fuck offdon't put me down...don't think I'm an idiot... but in fact I can see now the woman was being genuine and affectionate." For me was evidence that he was beginning to heal. The moment had remained alive in his mind and continued to be transformative. It was a therapeutic moment that had wings because it was incremental...its effect extended in time.

Themes of growth in awareness and cognitive understanding are continued in the following passage that reveals the intersubjective experience of both client and therapist. Although this excerpt is packed with meaning in terms of the transference relationship, therapeutic mistakes, and relational depth, it also illustrates the effect of specific meaningful moments in the therapeutic environment and their impact on change

I am thinking of a patient who came for just a few sessions. She wanted a specific thing and was clear about it. She was pregnant and had some anxieties around the management of her mother during the birth of her child. Her major concern was that she would focus on her mother's emotional state and try to soothe her if she was upset rather than focus on the birth. A very important moment in the therapy came when she

brought in a dream about space...that her unconscious had lots of space. I knew she had a strong mother transference so I asked her to fill this space with what she'd received in the therapy room... so it would be available to her at the birth....It was an incredibly intense moment...full of silence, eye contact, tears, heart connection and trust...we were in absolute sync...she knew it would be with her at the birthand it didn't matter what her mother did...she'd received what she needed.

Discussion: A Therapeutic Moment and World in a Grain of Sand

Although the notion of therapeutic moments relates to this research, theorists have long acknowledged that specific healing moments occur in the interpersonal encounter between client and therapist (Merleau-Ponty, 1973). Perhaps the best known of these are Buber's (1967) 'dialogic moments, Rogers' (1959) 'effective moments', and Stern's (2004) 'present moments'. Although these mechanisms stem from different therapeutic orientations, they share commonalities that capture the attributes of therapeutic moments identified by this study. Perhaps Stern sums up these instances best with his eloquent description of this client/therapist encounter as a "shared feeling voyage" that makes up a "world in a grain of sand" (p. 172).

Dialogic and Effective Moments

Buber's I /Thou (1967) 'dialogic moments' are adapted to the therapeutic encounter to describe instances between therapist and client that acknowledge the presence of relational depth. During these moments of meeting both parties create an openness to influence that signals their emotional availability. Constantly changing patterns of availability bring a state of relational presence, realness and authenticity to the therapeutic environment. This creates a sense of expanding participation, engagement, and openness between both parties (Jordan, 1986).

Cissna and Anderson (2002) contend Rogers' 'effective moments' are similar to Buber's 'dialogic moments' in that they share five common features. These include recognitions that: i) As therapists and clients are active participants in therapy, they seek to meet each other mutually in

therapy; ii) Mutuality between clients and therapists occurs even though their roles within the therapeutic relationship may be unequal; iii) This quality of mutuality lasts only for a few minutes or less; iv) Moments of genuine mutuality between therapist and client facilitate client transformation; v) Clients are likely to experience effective and dialogic moments more frequently as their relationships with therapists become more mutual. Thus as these relationships expand levels of mutuality, the equality of their relatedness expands until the therapy is complete. In view of these characteristics, therapeutic moments identified by this study typify Rogers' (1957) notions of 'effective moments', 'moments of movement', 'molecules of therapy', and 'existential moments'. Indeed Rogers suggests that psychotherapy embodies a series of crucial moments that are fleeting in quality. Similarly, therapeutic moments correspond to Buber's (1958) 'dialogic moments' as brief interludes in which "two people happen to one another yet disappear in the moment of their appearance" (Cissna & Anderson, 1998, p. 78). Likewise Stern's (2004) conceptualization of critical moments in psychotherapy share much in common with the ideas of Buber (1958) and Rogers (1957). His understandings posit 'present moments' within the therapeutic environment reflect subjective experience that changes the course of psychotherapy. In his rigorous attempt to describe these crucial instances, Stern relies heavily on a phenomenological perspective. Accordingly, he distils the structural essence of these moments through a microanalysis of psychotherapeutic experience viewed through an analytic lens. This seeks to appreciate "the small but meaningful affective happenings that unfold in the seconds that make up now" (p. 8).

Present Moments

Essentially, Stern (2004) contends therapy sessions constitute a series of 'present moments' that are driven by a desire for contact within the intersubjective field. These moments are the "ordinary...stuff of low-level everyday drama" that constitute "the archipelago of islands of consciousness" (p. 11). He goes on to state: "these islands are the psychological foreground...the primary reality of experience" (p. 21). As present moments are understood implicitly, they create a background of

knowing in human relating. In this context the therapeutic dyad moves along, linking present moments that last for only several seconds. As this process develops, trust between client and therapist grows. However this momentum prepares the ground for the emergence of a special moment between client and therapist coined a 'now moment'. Stern posits 'now moments' are charged, affective events that threaten to destabilize the therapist/client relationship and the intersubjective field. As this requires immediate resolution, therapist and client respond by creating a 'moment of meeting' that brings a quantum change to their interpersonal connection. Both therapist and client experience a fleeting intersubjective consciousness Sander (2002) describes as 'specific fittedness'. The presence of this phenomenon leads both parties "to know and feel what the other knows and feels" (p. 39). This dynamic of mutual experience enhances the relationship enabling client and therapist to pursue a joint yet different therapeutic course. Accordingly, Stern refers to this as the emergence of an intersubjective consciousness that he describes as follows:

When two people co-create an intersubjective experience in a shared present moment the phenomenal consciousness of one overlaps and partially includes the phenomenal consciousness of the other. You have your own experience plus the other's experience of your experience as reflected in their eyes, body, tone of voice, and so on. Your experience and the experience of the other need not be exactly the same. They originate from different loci and orientations. They may have slightly different coloration, form, and feel. But they are similar enough that when the two experiences are mutually validated, a "consciousness" of sharing the same mental landscape arises (p. 125).

Thus, Stern (2004) advances the view that present moments of meeting arise when therapist and client make intersubjective contact. This occurs when both parties engage in the mutual reading of each other's minds or felt intentions; when they see and feel approximately the same mental and emotional landscape; when they resonate with and participate in each other's experience; when they are in synchrony with each other and

when they are affectively attuned, in symmetry, and engaged in dyadic coordination (Hannush, 2007). Accordingly, Stern posits that a series of these moments of meeting accumulate over time and account for incremental, progressive change in the form of sequential shifts that evidence effective psychotherapy. Although therapeutic moments are identified as sub-theme of the overarching theme of significant moments, the study also ascertained that vulnerable moments experienced by both client and therapist are also a sub-theme of this overarching theme.

Sub-Theme 2.3: Vulnerable Moments

The findings of this study establish that when clients reveal aspects of themselves they are usually too fearful to expose, they often experience fundamental shifts characterized by insight and personal growth. Moreover four participants stressed these fleeting moments are mutual moments of therapist vulnerability as well.

Research Excerpts

It's about being therapeutic when the person takes a riskwhen they don't resort to usual defensive strategies ...when they allow themselves to be seen in a less protected way...It's that moment when a new quality of contact is possible...Sometimes it's when they let go of their fearor they're testing out whether I'll repeat past hurts... I'll get this sense of the absolute crucialness of my response because the client is very vulnerable... they've put something out that's very shaky and shamefulSo how I respond determines whether they feel safe enough, or understood enough, or something enough to keep it out there. But I deal with it authentically....not in a way that's just soothing...So we both feel uncertain and vulnerable ...they're tentative and hesitant and I'm unsure how to make the encounter helpful.

This first extract stresses vulnerable moments are opportunities seized by clients that enable them to contact aspects of themselves without resorting to usual defense strategies. Moreover this movement often leads to change.

Then a vulnerable moment came. Her voice seemed strained ...She'd put this new, precious part of herself out in a diffident sort of way to and was waiting for my response. And I nearly missed it....and would have if I'd stayed with my usual pattern of relating. But suddenly it all clicked... She'd finally got she had enough of an internal mother to parent herself and her child ...she didn't need to hang on to her biological mother anymore but she needed me to say it was okay. She'd made a shift in the transference from seeing me as an idealized mother to seeing me as an idealized therapist. She was no longer saying: "Help me, Mum, I'm lost in myself" to "I need your support, woman to woman". So our connection became more adult. I made a disclosure about my own mothering she found very encouraging and I noticed a shift in her appearance...the colour of her skin had changed. She'd come in looking like a primary school kid but now she looked more adult, more sexual. She wasn't a kid anymore.

This excerpt and the next passage that follows highlight the emergence of therapeutic vulnerability. In particular, this instance stresses that when both client and therapist are aware of a qualitative difference in relating, this heralds a new development encapsulated in a moment of mutual vulnerability. Moreover these events are characterized by feelings of instability that threaten to destabilize the client/therapist relationship. Furthermore this excerpt raises the question as to whether therapy really functions in this way. Are therapists content to find the odd jewel in the dross of sand? Is all the other time spent in therapy just preparation for these gems, or is the non-liminal time used to develop understandings that enable these insights to occur? Finally a typical example of a vulnerable moment is revealed in the next excerpt.

I've only seen this client three times. He is a very successful man in his fifties but for many years he's denied a lot of his own subjective experience because he's been so immersed in his professional life. The first two sessions were about his history, life experience and so on...In the second session he told me that his first marriage ended in his early twenties and it was fairly obvious that this was a very painful experience and probably one that he'd never really come to terms with. So about half

way through the third session I invited him to go back and talk some more about this event. As he reflected on what happened when the marriage ended, I made a comment that what he'd been telling me was very important because he was really letting me know that, beneath his professional competence, he'd been extremely lonely for a very long time. And when I said this...he went very quiet....I could see a few tears well up ... And in that moment there was a sense that he faced something that had been there a long time... but that he could not...and would not articulate it I held his gaze...and did nothing as I wasn't sure how to respond... I felt really uncertain...and wobbly...in a good sort of way....but then I realized it was a moment of contact ... In that moment things really clicked into place for him... I think this experience was something he really wanted to honour... because he'd told me about it in the second session in a way that said "I'm not going to discuss it... or give you any further information...even though I really wish I could"...And I think my comment about him being lonely was useful... I knew he had a yearning as well as a fear about letting his guard down...So when I used the word 'lonely' it gave form to his experience..... He got in touch with what was really there.... And I think the fact that I went back to it in a deliberate, non-confronting way... in the next session...and said I'd like to know more about that part of him... was very important. ... I think it helped him feel safe enough to go into that part of himself.

Specifically, both parties experience intrapsychic and interpersonal anxiety when the client re-connects with an aspect of himself he had previously hidden from view. However as the therapist responds to this development in an empathic, caring manner, the vulnerable moment leads to a shift that evidences effective therapy. Although the changes in the client were subtle, they laid a strong foundation for further developments.

Discussion: Implicit Internalized Dilemmas

This study asserts vulnerable moments are significant moments within a therapeutic encounter that contribute to effective psychotherapy. This finding affirms the self-psychological and intersubjective schools that incorporate the vulnerable moment as a theoretical construct (Livingston,

1999). Both frameworks contend these are episodes of heightened affect associated with internal conflict and personal dilemma. Essentially, these theoretical notions view vulnerable moments as opportunities for individuals to experience the dilemma of facing their deepest fears as well as the challenge of overcoming them (Farber, 2006). Although true vulnerability occurs in brief moments, the courage to face this in an intimate relationship is an ongoing personal struggle. Thus the capacity to experience vulnerability is inherently connected to strengthening of one's sense of self that leads to fulfilling relationships. Indeed this ability is one of the goals of treatment (Gans & Weber, 2003).

Vulnerability: A Transtheoretical Notion

Nevertheless, despite discourse that restricts this notion to specific therapeutic schools, the findings of this study suggest vulnerable moments arise in different contexts that evidence a commitment to client second order change. This view is supported by a growing number of clinicians such as Goldberg (1991) who suggests the internalized fear implicit in all vulnerable moments is the master emotion present in all therapies. In providing a clear conceptualisation of this notion, Livingston (1975) contends these are "brief periods when a person is able to let go of defenses and allow the self to be open, soft, and very, very, human" (p. 242). However despite this overt simplicity, Livingston (1999) argues this construct evidences an inherent duality. Specifically, when clients sense an impending vulnerable moment, they fear the danger of narcissistic injury as well as a new experience that brings validation, affect regulation, connection, and affirmation. Nonetheless, clients are also afraid of being overwhelmed by this duality as they suffer from a complex mixture of palpable shame and acute longings that inhibits mobilization of internalized resources. Consequently this push/pull dynamic prevents clients from confronting their difficulties. Therefore the creation of safe therapeutic environments is critical in overcoming this impasse as this enables the softening of client defenses so they may open up to the unfolding of long suppressed desires (Livingston, 2001). But is the push/pull conflicts part of the therapy, not just the emotional explosion? Could the client achieve

change without the luminal experience? Indeed, Bacal (1995) stresses therapist sustained empathic attention provides a holding environment for containing and processing painful client affect. Moreover informants in this study also suggested therapists experience great uncertainty in these destabilizing moments. Although this tension manifests as therapist sensitivity, it also assures clients of therapist emotional availability and their willingness to be deeply affected by client experience. This viewpoint is supported by Orange (1995) who contends that when therapists risk being authentically touched by client pain, this experience triggers their personal feelings of vulnerability. Accordingly, this enhances the capacity of therapists to explore vulnerability with clients that Ehrenberg (1996) describes as “the removal of psychic rubber gloves” (p. 277).

Summary of Significant-In-Session Moments Paradigm

The findings of this study established that specific, significant in-session events in the therapeutic environment induce client change. Furthermore, these instances are viewed as determinants of effective psychotherapy. As these in-session moments are said to occur within the intersubjective field of client and therapist, they were identified as an overarching theme of this research. Moreover, as significant moments within the scope of this study were identified as therapeutic moments and vulnerable moments, these constructs were viewed as sub-themes of this overarching theme. Specifically, therapeutic moments are viewed as turning points in the mutual development of client and therapist, whilst vulnerable moments are viewed as reciprocal client/therapist openings. Although the literature considers these interpersonal processes features of specific modalities, an emergent theme of this research posits these dynamics are transtheoretical processes. Accordingly, they are found in all depth therapies committed to second-order inner change. Essentially, as these events are complex multi-dimensional encounters, attempts were made to ascertain the informants of these moments. The next task undertaken in this chapter describes these efforts.

Overarching Theme 3: Informants of Significant In-Session Moments

This research established that therapist empathic inquiry informs significant in-session moments that lead to effective therapy and positive client change. As empathic inquiry this was identified as an overarching theme, its various forms are recognized as individual sub-themes. These include empathic imagination, immersion and attunement. Consequently, empathic inquiry and its constituents are explored as determinants of effective psychotherapy. Moreover, the transtheoretical nature of these notions and their therapeutic effects are reviewed in the light of informed commentary.

Sub-Theme 3.1: Empathic Inquiry

The notion of empathy stems from the German ‘Einfühlung’ meaning ‘feeling into’ another’s realm of experience (Lipps, 1885). This is distinguished from the experience of sympathy, as an act that ‘feels with’ or ‘sides with’ another (Clark, 2007). As all participants view empathy as an informant of effective therapy, it is considered an overarching theme of the study. The clinical vignette that follows captures the essence of this construct.

Research Excerpt

I’m seeing a client I’ve only seen four times. He’s a senior, successful professional and he’s come because he’s concerned about his marriage. But at some level I think much more is involved. He’s questioning his fulfillment in this later stage of life and although he presents as calm and confident...I think there’s something of a split in his personality. One the one hand there’s the in-control competent professional personae he’s comfortable with....but another part of him is shy and self-doubting. And I think this part questions his lovability and its impact on his ability to relate to others. So I’ve maintained a stance of empathic inquiry because it would be easy to provide rational explanations that would make sense to him...but I don’t think it would help him. In the last session he described a behaviour that had a sense of narcissistic wounding and shame....So I stayed

with an experience-near position ... using my imagination to grasp his inner experience ...slowly unpacking it until we got a bit clearer...putting his sense of rejection and shame into words...staying with a not knowing, curious stanceby paying attention to his language and how he experienced himself physically.

This vignette reveals an experience-near position that led to the emergence of a significant moment in therapy that enhances therapeutic movement, effective psychotherapy and client change. Specifically, this passage highlights the empathic position that therapists adopt, to appreciate the experience of clients as they really are. This encourages the development of a genuine meeting between therapist and client. Additionally, the excerpt reveals empathic inquiry is an essential feature of therapeutic practice as it requires therapists to take note of language use in their efforts to steep themselves into client interiority. Thus both parties are engaged in the process of co-constructing symbols of experience through the language of empathic inquiry adopted to contact client affective experience. In turn this mobilises aspects of client interiority that are generally unavailable due to client defensive strategies.

Historical Development of the Understanding of Empathy

In the early development of psychotherapy Freud (1915) adopted the notion of *Einfühlung*, attempting to project himself into Michelangelo's statue of Moses to understand the inner feelings of this historical figure. This act initiated efforts to view empathy as a therapeutic process that led to a fuller understanding of other human beings. Although this instigated a plethora of diverse definitional understandings, most approaches view empathy as a strategy that comprehends cognitive and affective states. For instance, Fromm-Reichmann (1950) argues empathy is synonymous with intuition whilst McKellar (1957) claims it is a process whereby individuals put themselves in the shoes of another to obtain an understanding of their lives. Iannotti (1975) attempts a more specific explication by stating "empathy in its broadest sense refers to the responsiveness of an individual to the feelings of another person" (p. 21). Indeed, Medini (1975) contends it is an act of perception resembling a musical instrument in its ability to

respond to the vibrations of another. Alternatively Truax and Carkhuff (1967) proclaim empathy envisages the ability to sense the private world of another with sensitivity and communicate this to them.

In terms of therapeutic effectiveness, most theorists view empathy as a key component of therapeutic change (Shapiro, 1981). Rogers (1961) refers to the importance of empathic attunement as therapists who "sense the client's private world as if it were [their] own, but without losing the 'as if' quality- this is empathy and this seems essential to therapy" (p. 284). Rogers also describes this way of being as "temporarily living in the other's life, moving about it delicately without making judgments" (p. 142). However Lopez (1995) postulates Rogers' empathic focus is more cognitive than emotional. In contrast, more recent conceptualisations stress the subjectivity of therapists in holding this affective stance. For instance, Arnold (2006) states "psychotherapists understand clients most deeply by becoming conscious of their subjective reactions to clients" (p. 754). Andrade (2005) claims the reality of client and therapist connection occurs through the subjective, unconscious quality of empathy. These viewpoints echo Reik's (1948) who states individuals possess built-in listening systems designed to intuit another's unconscious by decoding interpersonal signals (Dosamantes-Beaudry, 2007). As this historical overview indicates the significance of this notion, the discussion that follows explores its meaning in the context of effective therapy.

Discussion: Empathic Inquiry and Effective Therapy

More than any other thinker, Kohut (1971, 1977) contributes to an understanding of the nexus between empathy and successful therapy. Specifically, Kohut bases his ideas of self psychology on empathic attunement, a process he views as the defining feature of psychoanalysis. Moreover, he wrote extensively about using empathic inquiry to understand clients from their point of view. Essentially he considered this a form of "vicarious introspection (p. 82)" that embodies the experience of feeling oneself enter the inner world of another. Moreover Jaenicke (2007) points out Kohut (1982) referred to empathic inquiry as a "mode of observation attuned to the inner life of man, just as extrospection is a mode of

observation attuned to the external world (p. 84)". Accordingly, Kohut portrays this construct as an information-collecting, data gathering activity undertaken from an experience-near position. Accordingly, this device grasps feeling states of clients through their own phenomenological lens.

Kohut (1982) postulates initially, therapists commence the process of empathic inquiry by entering into a state of resonance with client experience, looking at their encounters with similar feeling states. Secondly, therapists check whether these understandings meet the experience of their clients. Thirdly, through the use of interpersonal dialogue therapists arrive at an approximation of client experience. Reference to 'approximation' is deliberate as therapists are never free to abandon their own frame of reference. Essentially, they are compelled to view clients through their own subjectivity. However this is mediated through client/therapist conversations that co-construct 'truth' that is as close as possible to the view of clients. Hence, Orange, Atwood and Stolorow (1977) define the emergence of this phenomenon as the intersection of two subjectivities through the process of empathy.

Having provided an overview of the divergent features of empathic inquiry, it is clear this multi-dimensional process speaks to therapist subjectivity and attunement. However, complex descriptions of empathic inquiry suggest this notion is comprised of escalating stages of development that commence with empathic imagination, empathic immersion and end with empathic attunement. Accordingly, each of these notions is investigated as a sub-theme of empathic inquiry in the light of the prevailing literature.

Sub-Theme 3.2: Empathic Imagination

The study ascertains empathic imagination is an important interpersonal process used by therapists to envision client feeling-states in the initial stages of therapy. In effect, therapists employ their imagination to actively envision client experience. Thus the excerpts that follow reveal the dynamics of this process and its impact on therapist effectiveness and client change.

Research Excerpts

It seems to me that empathic imagination is a very important part of the therapy process...particularly in the early stages....when you're trying to develop attunement. It's about being half a step ahead in your efforts to reach inside client experience. When I use my empathic imagination I draw on my own life and what I've done to imagine something of what life is like for them. Then I try to put my ideas into words in a sort of a tentative, curious, explorative sort of a way.

This passage and the one that follows illustrate the significance of empathic imagination in the early stages of the therapeutic encounter that enables therapists to penetrate the affective experience of clients.

One tries to open up the subjective experience of patients through one's imagination from an empathic position. I was talking to a new patient who was distressed by a tiff with his wife. She refused to listen to him... just dismissed his efforts to talk... so he felt really rejected and was thinking of leaving her. I tried to imagine the event as he described it, to get a sense of his subjective experience using feelers and probes to slowly unpack what this rejection meant. My deliberate efforts to feel through my mind's eye helped connect me with a wounding experience of rejection that came from his childhood.

This demonstrates that empathic imagination enables therapists to formulate a sense of client landscape fuelled by therapist tacit knowledge gleaned from practice wisdom, research and informed literature and accumulated understanding of the world in all its diversity. The thrust of empathic immersion, revealed in this passage, focuses on therapist probes and feelers that seek entry to the interiority of clients. These aim to picture, envisage and experientially 'feel' the affect, behaviour and thoughts of clients that literally seeks to imagine the experience of 'being in their skin'.

Discussion: Function of Empathic Imagination

Therapists draw on their empathic imagination to transcend the limitations of the personal. Essentially, by actively imagining the life of clients, therapists grasp the nuances of client experience and ask themselves what clients wish to convey. This reflective stance provides therapists with clues as to client interiority that forms the basis of further exploration in the immersion and attunement phases of empathic inquiry. Thus therapists are empowered to discriminate between client core emotions and secondary affect. Although they do not invalidate the latter, therapists probe client experience beyond marginalized responses, to support clients in contacting more primary, adaptive responses. In effect, this empathic responding consists of tentative, cautious, exploration that implies a process of discovery. It is as if the therapist is holding up a flashlight to client ongoing momentary experience, observed, conjectured and fed back to clients. Essentially this demonstrates that therapists recognize clients are unequivocal experts on the events of their life (Greenberg & Elliott, 1997).

Nevertheless, although Margulies (1993) posits affect is an organizing beacon in developing empathic imagination, it is insufficient to fully understand situations. This view is informed by the understanding that client affective experience is always referenced to context. Thus empathic imagination is limited to a depiction of generalized affect as it lacks the personal, subtle shadings of individual experience. Accordingly, Margulies contends the notion of 'inscape', borrowed from Gerald Manley Hopkins, facilitates the development of empathic imagination. Specifically, inscape drawn from phenomenology, privileges sensory worldviews constructed through the act of placing oneself imaginatively in another's experiential world. This facilitates 'feeling into' client experience with the aim of comprehending it. Indeed, Bolognini's (2004) portrayal of empathic imagination as privileged moments that combine emotion, imagination, and reflection is commendable.

In seeking to 'understand' the experience of clients, through the process of empathic imagination, Flaskas (2009) alludes to two therapist

positions. Although both rely on the fantasy of self-in relationship-to-other, they are distinguishable. The first position moves from imagining sameness whilst the second position imagines difference. Essentially, the first fantasy of identification assumes therapists are sufficiently like their clients, so they try to imagine themselves in their situation, using resonances from their own experience to orient themselves to client interiority. The second position relies on a relationship fantasy of therapist difference, highlighting their foreignness. Thus therapists assume they will not be able to relate to client experience. Accordingly, they adopt an anthropological stance that actively uncovers client experience by asking questions and remaining curious. Although both positions reflect imaginative strategies that invite connection and shared understanding, each offers a form of connection that is lacking in the other. Thus, although the flexibility of this duality provides rich opportunities for empathic relating, the back-and-forth movement between these positions requires therapists to stay open to both kinds of imagining.

Sub-Theme 3.3: Empathic Immersion

The study also identified the sub-theme of empathic immersion as an informant of effective therapy. Specifically, therapist psychological immersion in client subjective experience was found to be beneficial. Essentially, therapist immersion in the psychological life of clients was considered to loosen boundaries between the parties. Consequently, client defence barriers were deconstructed leading to the emergence of a clear sense of self and other. Thus the excerpts that follow demonstrate this process.

Research Excerpts

I immerse myself in their world, paying close attention to their experience. Although I don't look for things deliberately, I do notice subtle differences... like visceral changes in the face, body and movements...I try to get a sense of their experience by an analogical search into my own life that resemble theirs...and this process usually leads to some sort of

interpretation. And if this hits the target.... then they feel seen, heard and understood.

This first example captures the level of engagement with self and other that typify the thrust of empathic immersion. The sense of aliveness, hyper-vigilance, and tracking of movement characterize this process. However, immersion is also enhanced by Schön's (1987) reflection-on-action and on-action, demonstrated in the following passage.

Turning points happen when therapists project themselves into the subjective world of patients...they put causative thinking aside and place themselves there as much as possible. A patient might say something about themselves. One way of responding would be to make some sort of explanatory comment aimed at finding out what lies behind the statement. This is an experience-far position. Or the therapist could place themselves inside the patient's experience to open it out....imaginatively.... as much as possible. I think their capacity to be with patients from the experience-near position is the thing that makes therapy work!

Discussion: Function of Empathic Immersion

Both excerpts demonstrate therapists 'embed' themselves in the experience of clients as they explore their world. Moreover these passages imply empathic immersion is not a process whereby therapists guess, intuit or magically perceive client cognition and affect. However this kind of exploration does not mean that therapists identify with or are flooded or overwhelmed by another's feelings. Contrarily, empathic immersion requires therapists to engage in plodding, pain-staking trial and error conceptualizations. This aims to approximate the 'flavour' of client experience whilst retaining the observer position of the participant/observation stance (Rowe & MacIsaac, 1991, p. 248). Moreover Goldberg (1980) is adamant that empathy cannot be equated with an act or quality in a person's interactions commonly identified with love, compassion, or any other intense emotion. Rather, empathy is only relevant to human interaction if it results in a response or action that follows directly from experience-near observations. In fact, Kohut (1981) links

empathy and action whilst emphasizing their differences stating "introspection and empathy are informers of appropriate action" (p. 529). This implies therapists are only able to generate responses that are authentic, accurate, and fitting when they metaphorically step into the shoes of clients. Indeed, within the framework of self-psychology Kohut (1977) attributes the experience-near quality to empathic immersion provided therapist attention is focused on client subjective and affective experience. Brenner (1982) stipulates this activity takes on the appearance of "bedrock" in the mind of therapists when they look to both content and process features of client statements. Although this enables therapists to understand the world through client eyes, it also assists them to refrain from enacting interventions that are not derived from this data.

According to Kohut (1971), the presence of empathic immersion means therapists recognize affirmation and validation as client needs, together with their longings for an idealized protective figure. Thus, when therapists assume a stance of empathic immersion their actions function as attempts to resume a derailed aspect of client development. Consequently, the unfolding of these needs represents a central part of the curative process. Essentially, therapist empathic immersion in the subjectivity of clients ensures early infantile yearnings and fears of retraumatization are made available for interpretation. Indeed, Livingston (2009) suggests empathic immersion facilitates deepening of self-object transferences and exploration of underlying personal meanings and affects. Consequently, this interpersonal device underpins the healing process. Accordingly, Kohut considers that when therapists display empathic imagination and immersion this leads to deeper forms of empathic inquiry, termed empathic attunement. Although this notion derives from self-psychology, it has made an impact on a variety of modalities that view it as an informant of effective therapy.

Sub-Theme 3.4: Empathic Attunement

The final sub-theme that underpins the overarching theme of empathic inquiry is empathic attunement. Although this notion is well-described within the self-psychological paradigm, it is increasingly

integrated into a number of therapeutic modalities. Within self-psychology, empathic attunement focuses on emergent client developmental needs and their affective meaning. These outcomes are prioritized by therapists to amplify current and past client yearnings and disappointments. To accomplish this aim, therapists apply sustained attention to early, infantile affective experiences that emerge. Consequently, as therapists legitimize client subjective experience through appropriate attunement, this is said to empower clients to work through confronting memories and feelings. With this in mind, Erskine, Moursund, and Trautmann (1999) makes the point that attunement goes beyond empathy as it identifies attunement as a process of communion and unity of interpersonal contact. He posits this is a two-part process that begins with identifying client sensations, needs and feelings and then communicating this to them with sensitivity. More than Rogers's (1951) understanding or Kohut's, (1971) vicarious introspection, attunement is a kinesthetic and emotional sensing of others. This 'knows' client rhythm, affect, and experience by metaphorically being in their skin. Accordingly this goes beyond empathy as it creates a two-person experience of 'unbroken feeling connectedness' that provides a reciprocal affect and/or resonating response.

Research Excerpts

I saw this guy recently who only wanted six sessions. Although he was very successful at work he was having problems with his kids. In the first session I got the sense that he was stuck because he parented just like his mum and this didn't work for his kids. And I realized he would have to shift pretty quickly to avoid losing them. In the second session he told me his job as a senior manager meant he had to oversee large numbers of people. This demanded spur-of-the-moment decisions to major and multiple challenges and crises. And I understood he did this really well. And as he talked I realized that his work skills could really help him at home. He needed to bring this highly functioning part of himself into his role as a father. So following on from this I asked him why he couldn't bring his work skills home. Initially he imagined the whiteboard he used at work and listed off the skills he used to resolve problems. Then I said to him "It

sounds like you feel in control and calm at work because you move into action very easily and quickly there....Can you bring some of that expertise home with you and use it on your kids?"I knew I had to link his deficits at home with his strengths at work... and as I spoke he got in touch with some intense feelings of loss. So by the third session he was really 'with' the pain of his childhood. He admitted he'd always felt inadequate in his mother's eyes and this belief had hindered him in his close relationships. I asked him a lot of questions around his fear of intimacy ...and we moved pretty quickly...the mother transference he projected onto me worked well...And he was pretty robust...I also felt very connected to his experience. He recognized that childhood fear was blocking his sense of self-worth. By the sixth session he's let go of all the stuff he carried from his mother...so I re-introduced the whiteboard and asked him to think about his work skills again and whether he could use these strategies at home. He spent the rest of the session feverishly writing a list of all the things he could do....and that was our last session...but about three months later he'd sent me a card saying that things had improved with his children but he intended to do some more personal work in the future.

This first excerpt reveals empathic attunement is a transtheoretical process shared by various therapeutic modalities. The second excerpt demonstrates that empathic attunement is a significant factor in enhancing client positive change.

All therapies talk about attunement although they may not use this exact phrase. They might direct you to 'feel out' clients or build rapport, be empathic or whatever. But they all mean the same really. So when a patient is angry or anxious I try to get a sense of their experience and communicate what I feel to them. And questions come up like: what's wrong in this person's developmental history; where's the deficit? When I attune to their experience, it helps me to go to that part of the client that's stuck.

Discussion: Empathic Attunement as a Transtheoretical Notion

According to self-psychological and intersubjective frameworks, therapist continuous efforts to practice empathic imagination and empathic immersion lead to expanding attunement. In this context, empathic attunement refers to the increasing ability of therapists to 'feel into' the content and process aspects of client experience to approximate their affect. However this interpersonal process also incorporates the impact therapists have on clients. Moreover, empathic attunement is not limited to moment-to-moment affect connections of a particular thought, idea, or fantasy. Rather, it retains the cumulative effects of client experience that is perceived, understood, and expanded by therapists. In this sense, empathic attunement embodies the whole emotional canvas of therapists. This incorporates client shifts that add to an ever-widening portrait of their interiority. Thus empathic attunement implies the presence of intersubjectivity that means client and therapist share their subjective worlds (Attwood & Stolorow, 1984).

Nevertheless, despite its association with relational analytic psychotherapy, empathic attunement is may be found in various therapeutic frameworks committed to second order identity change. Drawing on Rogers's (1975) definition of therapeutic empathy, various modalities view therapist skills of attunement and communication as essential to sustained empathic engagement and development of relational bonds. Specifically, this stance posits therapist empathic attunement facilitates a number of client outcomes: these include i) client ability to disclose specific, emotionally salient personal narratives without fear of censure (Angus, Lewin, Bouffard, & Rotondi-Trevisan, 2004); ii) client identification of core relational and emotional themes (Greenberg, 2002; Luborsky, Barber & Crits-Christoph, 1990); iii) therapist formulation of comprehensive case conceptualizations (Goldfried, 2003) and iv) the articulation of shared therapeutic goals. Moreover, therapist empathic attunement helps clients engage in active, self-reflection for the expression and symbolization of primary adaptive emotions and core beliefs (Greenberg, 2002). This leads to the construction of new, coherent, and empowering personal meanings

(Angus, Levitt, & Hardtke, 1999). Therapist empathic attunement also helps to sustain client active self-reflection in the therapy hour engendering a heightened sense of personal agency and mastery (Bandura, 2006; Frank, 1961). Additionally, experience of an empathic relational bond and heightened personal agency positively impacts on client expectancies. This leads to enhanced motivation for their engagement in therapy tasks and goals (Westra, 2004). Moreover therapist active attunement to fluctuations in the depth and affective tone of therapeutic bonds function as early warning signs in the detection and repair of alliance ruptures (Safran & Muran, 2000).

Furthermore communication of therapist empathic understanding and validation is viewed as facilitating a number of important client outcomes. Firstly, the experience of disclosing deeply personal and painful experiences to therapists, feeling accepted and understood, may be the basis of new client corrective interpersonal experiences (Castonguay & Beutler, 2005; Pachankis & Goldfried, 2007). Secondly, when therapist empathic understanding is experienced as relieving and soothing, this enhances client capacity for emotional self-regulation (Elliott, Watson, Goldman, & Greenberg, 2004). Thirdly, therapist empathic validation of client accounts of positive change helps clients bring saliency and meaning to these experiences (Hardtke & Angus, 2004). Accordingly this facilitates emergence of insight and new, more positive views of self/self-identity (Castonguay & Hill, 2006).

Summary of Informants of Significant-In-Session Moments

This study determined that significant in-session moments, coined therapeutic moments and vulnerable moments induce effective therapy and bring about client change. Furthermore this research ascertained these in-session moments were informed by the empathic inquiry of therapists. Accordingly, therapist empathic inquiry was identified as an overarching theme of the study, supported by the sub-themes of therapist empathic imagination, empathic immersion and empathic attunement. As these overt and covert processes are forms of implicit procedural knowledge, they fall within the practice wisdom of practitioners. Although this hierarchical

taxonomy of expanding empathy has been identified as features of intersubjective and self-psychological psychotherapy, this research indicates that these notions are transtheoretical and are found in most forms of depth therapy. As this has implications for training and professional development, the significance of these findings is discussed within the ambit of the next task of this chapter.

Significance of Findings of Phase Two of this Study

The implications of the second phase of this research are considerable as they offer an alternative way of identifying the causes of effective psychotherapy and internalized client change. In part this stems from the ontological and epistemological understandings that underpin the study as well as its substantive findings. Accordingly, the significance of the study is addressed in terms of these philosophical notions that infer the researcher's positioning.

Implications of Researcher Position in Phase Two

Firstly, although the research position adopted by this study does not invalidate empirical research that previously examined what makes therapy work, it throws light on this question based on the practice wisdom of therapist experts. Whilst this stance identifies common factors and interpersonal processes recognized by the techne of controlled trials and evidence-based praxis, it explores these influences from the perspective of practice wisdom. Accordingly, this approach provides a 'real' world contextual flavour that is absent from empirical investigation. Thus, this study infers a critique of the rationalist, positivistic medical model that currently dominates psychotherapeutic investigation. Consequently, its constructivist thrust illuminates informants of effective praxis, co-created by therapist and client. Although this is rooted in postmodern ideas, this duality is rarely considered when considering what makes therapy work. Indeed much prior research investigating this question is restricted to positivistic assumptions.

Moreover as indicated in the literature review, this "bonfire of the vanities" (Duncan & Miller, 2000, p.174) achieves little in terms of

knowledge development. In part this stems from its pre-occupation with 'therapy wars' (Cooper, 2008). Although investigative thrusts spearheaded by outcome researchers, Lambert (1992), Hubble et al. (1999), Wampold (2001), Norcross (2002) break with this tradition, they fail to take account of constructivist, exploratory investigation. Whilst these investigators privilege common factors as the source of effective therapy, their focus on quantitative, empirical inquiry omits attention to the richness of phenomenological, judgment-based decision-making. This is even more regrettable in view of recent recommendations (Duncan et al. 2010). This encourages researchers to examine therapist actions and attitudes when considering what makes therapy work. Whilst this critique acknowledges the value of this kind of positivistic research that investigates therapist input, it also honours constructivist, discovery-oriented explorations of practice wisdom. Consequently, in view of its findings, it is that suggested both forms of research be implemented in future to ascertain even more clearly what makes therapy work.

Secondly, this study captures implicit procedural knowledge that exists beyond the range of human awareness. As much previous research examining the determinants of effective therapy demonstrates experimental methods, they contrast with the findings of this study that embody declarative, propositional knowledge. Although empiricist research provides valuable insights as to the informants of therapeutic outcome effects, it fails to explore implicit processes such as in-session covert and overt dynamics. Contrarily, this study pierces the veil of implicit practitioner understandings by conducting conversational, unstructured interviews with this cohort. Accordingly, new explicit understandings emerge through this exploratory process, co-constructed by informant and researcher. Although this highlights the importance of Dewey's (1933) practical reasoning, Polanyi's (1967) tacit conceptualisations, and Schön's (1983) notions of reflection, nevertheless it has been argued these are afforded a secondary status within the context of psychotherapeutic research. As the science-practitioner model (Raimy, 1950) continues to dominate psychotherapeutic investigation, it is hoped that postmodern

constructs such as reflective practice make further inroads in this realm (Milne & Paxton, 1998).

Thirdly, the aim of this research focusing on the gleaning of practitioner knowledge corresponds with the latest recommendations of leading researchers. Specifically, Duncan et al. (2010) suggest the praxis of 'super-shrinks' be examined in empirical terms to elucidate therapeutic mechanisms that lead to client change and effective therapy. Accordingly they posit that:

It is unfortunate that little effort has been expended on studying the characteristics or actions of effective therapists....it is somewhat distressing how little research has been devoted to the subject. Instead the field became preoccupied with identifying effective "therapies." With the therapeutic factors now firmly established and feedback acknowledged as a viable approach for realizing appreciable gains in effectiveness, a new finding is directing us to the next frontier in psychotherapy research. Studies tracking the outcomes of thousands of therapists and clients have confirmed the significant role clinicians play in the outcome of therapy. As just noted, a cadre of clinicians consistently achieves consistent results. The existence of large-scale databases now opens the door for researchers to isolate the best from the rest and identify patterns associated with excellence (p. 425).

Although these suggestions are welcomed, it is postulated that implicit master practitioner knowledge gleaned from this study are also likely to enhance and augment the empirical feedback envisaged by these authors.

Fourthly, the study seeks to tap the implicit, procedural knowledge of expert therapists with regard to the informants of effective psychotherapy. Although there have been many previous attempts to identify what makes therapy work, in the main, these are confined to the pursuit of declarative knowledge. In contrast, this project focuses on procedural relational knowledge, operating outside conscious awareness or

language. Although this raises significant challenges, this study demonstrates the feasibility of this approach that is greatly dependent on the selection of appropriate methodology. Whilst this research embodies intersubjective co-construction, attuned participant/researcher meetings and reflexive, receptive responses, it is envisaged that similar non-reductionist approaches are a viable means to glean practice knowledge. Alternatively, it is anticipated the research design constructed in this study, may be beneficial in gleaning practitioner wisdom beyond the domain of psychotherapy.

Fifthly, it is important to point out the attributes of design implemented by this study are similar to many of the interpersonal dynamics that characterize the praxis of psychotherapy. As this investigation focuses on gleaning expert knowledge from the implicit, relational realm through the use of the reflective verbal domain, this epistemological stance resembles findings of the Boston Change Process Study articulated in its recent publication, *Change in Psychotherapy* (2010). Specifically, this exploratory research links implicit relational knowing and verbal reflective knowledge by positing the implicit relational domain refers to knowing about how to be with another affectively, interactively and cognitively. In addition, it interprets verbal reflection as the ability to re-experience a relational happening in a different context so that the original experience is reorganized. In effect, this approach suggests that although implicit and reflective-verbal domains of knowledge are not isomorphic, they are deeply familiar to each other. Accordingly this dynamic permits implicit aims and explicit motivation to join together, come into awareness and take on meaning.

Essentially, this position of the Boston Change Process Study (2010) is adopted by this investigation in its efforts to facilitate the verbal reflections of expert therapists regarding active agents of effective therapy and client change. Special attention is directed to the moment-to-moment changes between therapist and client that also manifest in the interpersonal processes that characterize these encounters. Having outlined the significance of the study, in terms of the nature of knowledge brought

to the question that asks what makes therapy work, the last consideration of this chapter reviews its substantive findings and their contribution to the domain of psychotherapy.

Finally, this phase of the research highlights the methodological contribution of Schön's (1987) reflection-in-action and reflection-on-action. The notion of reflection-in-action underpins researcher analysis of research material gleaned in this phase of the study. This material embodies data gleaned from collaborative co-constructed conversations between participant and researcher as expert practitioners ponder the features and influences of effective therapy. This process is informed by Schön's reflection-on-action, highlighting the parallel reflective processes of this study. Indeed this duality emphasizes the importance of practice wisdom that is at the center of this qualitative exploration. As argued in previous chapters the interrelation of these reflective processes help to substantiate the credibility of this research as its findings emanate from comparable, correspondent processes. In short, participant perceptions and researcher analysis of these perceptions are based on analogous constructs. Although these practices are grounded in Aristotle's (1976) *phronesis*, Schön (1987) offers guidelines to enhance the significance of practice wisdom as legitimate scientific knowledge within the human realm. Although this departs from the dominant discourse of the rational scientism of the natural sciences, it is argued the ontological and methodological stance that underpins the practice-based findings of this research phase is meaningful and significant.

Implications of Phase Two Substantive Findings

Firstly, as a number of notable theorists argue therapist knowledge is a "neglected variable" (Garfield, 1997, p. 40) in psychotherapy, this study addresses this deficit by focusing on subjective understandings of therapists. This contrasts with the dominant research thrust in psychotherapy, the randomized clinical trial. However, whilst contributing to the domain of psychotherapy by increasing evidence of its efficacy, this approach does not address the unique contributions of therapists. Indeed, in

some ways, the adoption of randomized trials inadvertently obscures the role of therapists in this endeavour (Beutler, 2009).

In addition to investigating therapist knowledge, this study also examines perceptions of peer-nominated clinicians to explore their implicit understandings regarding what makes therapy work. Although qualitative and quantitative studies conceptualize the attributes of mastery (Jennings et al. 2003; Jennings & Skovholt, 1999), they do not investigate the determinants of effective therapy from this point of view. Thus, in contrast to artificially of clinical trials, this study identifies new forms of procedural and propositional knowledge based on contextualized, real-world understandings regarding what makes therapy work.

Secondly, the contents of these real-world understandings identify clinical principles that encourage client change and effective therapy. Although these precepts fall within the domain of common factors and interpersonal process, there is no mention of specific modalities and their impact on outcome effects. This confirms current trends in outcome research that posit specific theoretical frameworks and orientations have a limited impact on therapeutic effectiveness. Contrarily, this study underscores the principle that clients, therapists and their relationship together with reciprocal relational processes make therapy work.

With regard to client influences, these findings are significant as they establish that, in the context of depth therapy, a number of transtheoretical features are likely to induce effective therapy. Specifically, this research contends client symptoms, their psychological mindedness, reflexivity and openness to change are features of client interiority that invite change. Although some of these characteristics are recognized in previous research, they are not associated with effectiveness research. Moreover, these findings represent reflections of an eclectic cohort of experts who identify these attributes as informants of successful therapy. Although prior empirical research suggests client factors are informants of positive outcome effects, this study implies that when therapists facilitate development of these client traits, they are more likely to enhance change.

Thus these client features may be viewed as determinants of effective therapy.

Likewise, therapist attributes of authenticity, clinical acumen, presence, and receptivity are viewed by this study as transtheoretical features that effect client change. Moreover the ability to hold paradoxical tensions of the participant-observer stance and the executive and caring functions are also identified as determinants of effective psychotherapy. In the same way that client attributes support effectiveness, these therapist attributes are not new discoveries in terms of therapist characteristics. However, from the perspective of expert therapists it is the first time these features are associated with enhanced effectiveness. Thus, in terms of the nexus between common factors and therapeutic success, the findings of this study are substantive. They provide significant guidelines regarding 'super-shrink' considerations of the salient factors that lead to psychotherapeutic success. This is even more persuasive as it is derived from implicit relational and verbal reflective knowledge.

Thirdly, perhaps the most significant finding of this study relates to the domain of interpersonal processes, generally ignored by effectiveness research. Specifically, this study highlights the role of relational dynamics within the intersubjective field of the therapeutic environment and their impact on change and effective therapy. Constructs such as relational depth and its components are identified as reciprocal, intrapsychic, and interpersonal processes that influence effective therapy and client change. In particular, the study acknowledges the mutuality of client/ therapist development in moments of meeting. Clearly, process change is viewed as a dyadic, dialogic movement led by the relational reciprocity of therapist and client. Furthermore, the dynamics of these processes facilitate shifts in client and therapist. Although these phenomena are identified in previous psychoanalytic research as dyadic states of consciousness, this West Australian establishes they are identifiable in other forms of depth therapy. Accordingly, these notions are acknowledged as pantheoretical processes that enhance client and therapist change. In short, the mutual effect of these processes on both members of the therapeutic dyad is considered an

innovative and emergent contribution in determining what makes therapy work.

Fourthly, within the context of process determinants, this research also amplifies understandings regarding the importance of significant in-session events on client change. Although specific instances that function as turning points in client development are coined therapeutic moments by this study, similar phenomena are previously identified in various modalities. Specifically, Stern's (1998) conceptualization of 'present moments' in psychoanalytic therapy resemble Buber's (1970) existential 'dialogic moments' and Rogers' (1951) 'effective moments'. Consequently, despite small differences, this research establishes these meaningful moments are common to all depth therapies. Therefore these notions are viewed as another example of transtheoretical influences that facilitate therapeutic success. Additionally, the study ascertains that a three-phased hierarchical taxonomy of therapist empathic inquiry has a substantive impact on the development of these significant in-session moments. Although a review of the literature indicates the notion of therapist empathic attunement is associated with a variety of depth therapies, the preceding states of therapist empathic imagination and immersion are far less common. Thus the identification of this construct as an expanding form of empathy has implications for future research.

Training and Professional Development Implications

The findings of this study have a number of consequences that impact on the training of psychotherapists. Perhaps the most significant confirms that the success of psychotherapy largely depends upon the development of implicit relational knowing within therapists. As this competency is generally beyond the range of human awareness, this raises the issue of how trainees may be assessed in terms of their potential to acquire this skill? Should this be based on a combination of academic competency and/or interpersonal competency as is the current practice in West Australian universities and private training contexts that facilitate psychotherapy training? How can interpersonal competency be assessed anyway? Is the process of interviewing potential candidates likely to

illuminate their capacity for implicit relational knowing? What is the best way to assess an individual's capacity to develop implicit relational knowing?

In addition, as this study has ascertained that implicit relational skills are considered a central feature of competency and effectiveness, how are these skills acquired? The expert literature and the views of participants within the first phase of this study consistently demonstrate that the informants of therapeutic mastery depend on therapist cognitive, relational and emotional proficiency. Furthermore, these perspectives view therapeutic expertise as an outcome of family and relational developments that occur early in life, enhanced by increasing insight acquired throughout the lifespan. Although, initially mastery was confined to cognitive development, this has gradually expanded to these wider interpersonal domains. Furthermore, the relational turn in psychotherapy infers greater interpersonal relatedness is required of effective psychotherapists. Thus the findings of this study provide guidance and direction regarding the kinds of relating required by therapists to advance their success and client change. Finally, as this study contends implicit relational knowledge informs therapeutic effectiveness how does this focus on relatedness sit with Boulder's science practitioner model? As practitioners are critical of Boulder's techne approach to research, clinicians argue the practitioner aspect is ignored by educators and trainers. Thus, it is likely that this study's stress on relational competency is a substantive challenge to the Boulder model.

Limitations of the Phase Two Findings

The findings of the second phase of this study are grounded in research material co-constructed by participant and researcher subjective understandings. As the focus of investigation uncovers the determinants of effective psychotherapy based on the perceptions of expert psychotherapists, this raises a number of ontological, epistemological, and methodological challenges.

Firstly, as this exploratory thrust focuses on the gleaning of expert tacit knowledge, it privileges the subjectivity and intersubjectivity of participant and researcher. Essentially, this epistemological thrust critiques the zeitgeist of evidence-based-practice that currently dominates psychotherapeutic research. As the latter privileges 'objective' truth claims based on a rationalist discourse, this relativist research counters this view by examining the informants of effective therapy through a different epistemological lens. With this in mind the methodological stance of the researcher centers on illuminating psychotherapeutic wisdom rooted in the pragmatic thinking of Dewey (1944), Peirce (1955), and Schön (1983). However, as the constructs advanced by these commentators are based on the notion of reflection, this practice is frequently rebuked for its imprecise and elusive nature. Indeed Rodgers (2002) points out these criticisms are contextually driven by a political discourse that favours reductionist, measurable, observable learning. Accordingly, as the inherent nature of human reflection is complex and rigorous, this intellectual and emotional exercise is frequently dismissed as nefarious due to the time it takes to do well. Although such challenges posed by reflective practice cannot be denied, the premise that underpins this second phase implies practice wisdom derived from reflection adds substantively to understandings that review what makes therapy work. Although this process fails positivistic generalizability and reliability standards, the value of reflection should not be dismissed as unscientific due to these limitations. As Dewey (1933) points out, it is essential to remember reflection is a meaning-making process that moves thinkers from one experience to another with a deeper understanding of its relationships and connections to other experiences and ideas. Indeed Dewey stresses the process of reflection is a thread that makes the continuity of learning possible as its roots are embedded in systematic, disciplined ways of thinking, grounded in scientific inquiry. Additionally, reflection constitutes community-driven inquiry that occurs through interaction with others that expands personal and mutual intellectual growth. Nevertheless, although this approach underscores the importance of practice wisdom stemming from Aristotle's notion of

phronesis, it is submitted that positivists are likely to argue the absence of rationalist reliability and generalizability is a deficit of this study.

However, although the usual parameters of positivistic empiricism are omitted, the replicability of the study is persuasive in view of current trends (Patton, 1980) that seek to embrace qualitative generalizability (Morse, 1999). Depending on contextual considerations and thick description, Schofield's, (2002) arguments with regard to Guba and Lincoln's (1982, p. 238) notion of "fittingness" may be applicable. Specifically, Schofield (p. 178) suggests this concept is applicable when a study's situation matches other contexts of interest. Accordingly, this comparability provides a realistic way of reflecting on generalizability in contrast with more classical qualitative views on generalizability. Essentially, Schofield posits that the specific conditions of transferability espoused by Guba and Lincoln make 'de facto' acceptance of qualitative generalizability plausible. Additionally it may be argued that Polkinghorne's (1991) arguments regarding assertoric knowledge and Peirce's (1955) notion of abductive hypothesizing extend the application of the study to domains beyond West Australian psychotherapy.

Secondly, as expert procedural knowledge falls within the ambit of Aristotle's (1976) notion of phronesis, the study necessitated a phenomenological stance that encompassed an exhaustive exploration of the study's purposive sample. Nevertheless the size of the research population was relatively small due to the method of sample construction realized in the first phase of the study. Additionally this restriction was enhanced by the limited numbers of psychotherapists practicing in Western Australia. Hence all these factors restrict a broad investigation of the research question even though the study itself was rich in depth and detail.

Thirdly, the scope of the study was further restricted by the theoretical loyalties of the research population. Although the research population in the first phase of the study was a heterogeneous population in terms of theoretical stance, the nine experts nominated for the second phase were all committed to depth therapy. Essentially, each participant had a strong commitment to varied forms of psychoanalytic psychotherapy,

client-centred/humanist approaches, and existential frameworks. Therefore it is suggested this study does not reflect the full range of psychotherapies practiced in Western Australia. Accordingly it may be regarded as a further limitation of this research. Furthermore as the majority of participants shared a common interest in a relational psychotherapy, this also limited the application of the findings of the study. Nevertheless, despite this restriction it is interesting to note that participants did not consider modality features an informant of effective psychotherapy.

Fourthly, as indicated throughout the study's second phase, a series of paradoxes confronted the researcher. Specifically, complex notions like objective and subjective change, valued client symptoms, the participant/observer stance, the real relationship and the 'as if' relationship come to mind. These paradoxes highlight the multifaceted nature of this research that was at times almost impossible to capture in the language of words. Again and again participants admitted their difficulty is describing the complex, non-verbal dynamics that characterize effective therapy. This task was made even more difficult by the presence of polarities and oppositional forces that created additional ambiguity and uncertainty in the development of themes co-constructed by participants and the researcher. Moreover the fact that this phenomenon was context-driven and dependent on non-verbal intrapsychic and interpersonal dynamics mobilized by client/therapist affects, cognitions and behaviours made the study even more challenging. Furthermore, conducting research that taps procedural wisdom beyond conscious awareness is difficult in terms of methodological design. Consequently, these problems further complicated usual efforts to obtain clear and consistent findings from investigative research. As this complexity is bound to raise questions about the rigour and veracity of the findings, attempts have been made to be as transparent as possible about the conduct of this study.

Chapter Five Schematic Outline (Part A)

Phase II: Interpersonal Processes That Make Therapy Work

Overarching Theme 1:

Relational depth in meeting between client & therapist facilitates therapeutic success

Broad ambit of notion with implicit qualities that include mutuality of connection, moments of meeting, relational presence, therapist/client realness & receptivity

Known to typify client centred approaches but study identifies them as pantheoretical constructs

Qualities characterizing relational depth equivocal yet they constitute individual sub-themes of major theme

Sub-Themes

1.1 Client/therapist mutuality promotes effective therapy

Client/therapist connection, a two-way process that induces reciprocal change

Counters medical model disputing therapist change

Client/therapist viewed as indissoluble psychological system: a codetermination that alters both parties

1.2 Specific moments in therapy turning points in change process facilitating effective therapy

Characterised by phronetic, context-driven, implicit relational knowing in form of tacit, procedural understandings that contrast with declarative techne knowledge

1.3 Relational presence of both parties within interpersonal therapy fosters effectiveness

Although therapist presence identified in literature as informant of therapeutic success, contribution of client presence generally overlooked

When clients present facilitates therapist receptivity leading to mutuality of movement & change

Effectiveness is directly attributable to level of relational presence operating within relationship.

1.4 Therapist/client realness is a significant determinant of therapeutic success

Realness viewed as joint authenticity, genuineness & congruence

Although realness a core condition of client centred therapy, Phase II establishes is transtheoretical, found in all effective therapeutic contexts

Notion of realness qualified by the 'as if' relationship implicit in therapy

Overarching Theme 2: Client change from mutative implicit processes beyond conscious awareness

Affective interactive & cognitive knowing depends on therapist ability to detect multiple meanings encoded in single messages: manifest as micro-processes occurring in improvisational modes

Sub-Themes

2.1 Effective processes facilitating change co-created by client & therapist coined significant events

Although curative responses driven by context within the intersubjective field, often criticized for diverse forms e.g. dialogic moments, now moments, present moments etc.

2.2 Two kinds of significant events foster change: therapeutic moments & vulnerable moments

Therapeutic moments when therapist & client make intersubjective contact enabling both to see & feel same mental & emotional landscape. Resonate together in a joint experience of affective attunement

Vulnerable moments when clients reveal aspects usually of themselves they are usually too fearful to expose. This process of experiencing vulnerability frequently leads to fundamental shifts in insight & growth.

Overarching Theme 3: Therapist empathy informs in-session moments leading to client change

Sub-Themes

3.1 Strong nexus between empathic inquiry, significant events & effective therapy

Therapists enter a state of resonance with client experience to encounter similar feeling states

Empathic inquiry encompasses three phases of investigation empathic imagination, empathic immersion & empathic attunement

3.2 Contribution of empathic imagination to client change substantive

Enables therapists to envision client feeling-states in the initial stages of therapy

Tentative, cautious, exploration that implies process of discovery

3.3 Therapist empathic immersion in client psychological field loosens boundaries: facilitates change

Characterised by aliveness, hyper-vigilance & tracking of movement

3.4 Empathic attunement strong therapeutic process fostering change

Increases therapist ability to 'feel into' content/process of client experience & approximate their affect

Retains cumulative effects of client experience as it is perceived, understood & expanded by therapists

Epilogue

Significance of Findings

Implications of Positioning of Researcher

- Does not invalidate empirical research previously examining what makes therapy work but elucidates this question based on practice wisdom of expert therapists
- Although role of common factors & interpersonal processes recognized as legitimate in techne controlled trials & evidence-based praxis, thesis explores same influences from phronesis:
- Thus represents critique of rationalist, positivistic medical model currently dominating psychotherapeutic investigation
- Breaks with traditional battle of the brands & drawn-out debate of common factors versus specific factors
- Unlike previous studies that pose this question, study seeks to tap implicit, procedural knowledge of experts using Schön's guidelines of practice-in-action and on-action
- Schön's guidelines of practice-in-action and on-action represent parallel processes within thesis
- Captures therapist expert implicit knowledge of effective psychotherapy gleaned through Schön's constructs but Schön's guidelines also used in co-construction & analysis of research material by respondent & researcher that underpin findings

Implications of Phase Two Substantive Findings

- As practitioner knowledge is 'neglected variable' of psychotherapy, study seeks to capture this in form of phronesis
- Gleaned through practice-based methodology differing from dominant positivistic thrust of randomized clinical trial
- Although qualitative and quantitative studies conceptualize attributes of mastery they do not investigate the determinants of effective therapy from expert point of view
- Study confirms current trends in outcome research that posit specific theoretical frameworks have limited impact on effectiveness
- Client features induce effective therapy substantively regardless of theoretical framework
- Practitioners contribute to therapeutic change significantly regardless of theoretical framework
- Interpersonal processes are powerful informants of change yet are largely ignored by dominant medical model privileging outcome research
- Training and Professional Development Implications
- Success of psychotherapy largely depends upon development of implicit relational knowing within therapists
- Raises a number of crucial issues with regard to how trainees might be trained & assessed such as:
- How can implicit relational skills be acquired?
- How does this approach fit with the medical scientific model that dominates psychotherapy?
- Limitations of Phase Two Substantive Findings
- Subjectivity of researcher & intersubjectivity of participants & researcher are both a shield & sword
- Small purposive sample
- Issue of replicability

SIX 'C" MODEL OF EFFECTIVE THERAPY

How can an intimate conversation have the power to heal an emotional problem?

Symington (2006) p. ix

In the final chapter of this thesis I present a transtheoretical, process-driven model of therapeutic practice that aims to foster psychotherapeutic effectiveness. This six-phased therapeutic construct incorporates processes identified by expert participants as informants of therapeutic success. As this representation stems from practice wisdom, it does not rely on techne's evidence-based empiricism for support. Alternatively, this theoretical notion derives from collaborative research conversations of master therapists engaged in the process of reflection. These constructions are derived from an enhanced capacity to facilitate action that delivers positive change. Drawing on Aristotle's (1976) notion of phronesis and Polkinghorne's (2004) rebuttal of technification, this model endorses wise decision-making shaped by context. Tacit, procedural interpersonal processes underpin this recursive, iterative dynamic that privileges conversations incorporating relational connection, collaboration, containment, challenge and client views of change. Each of these processes is explored as an informant of therapeutic change that functions as an interdependent aspect of a holistic encounter. This merger of processes is thought to transcend the sum of its parts. However as this theory is in its infancy, it is presented in the form of 'grand reflection' informed by critical reflexivity. Moreover the small research population and the cultural bias of the Six "C" Model of Effective Therapy require much more reflection and development.

The prologue of this thesis introduces Aristotle's (1976) paradigms of *techne* and *phronesis* as philosophical constructs that underpin the domain of psychotherapy. As the thesis question examines what makes therapy work, both perspectives are relevant. However as this exploration is limited to the phenomenological understandings of psychotherapeutic practitioners, it centers on implicit, procedural knowledge. For the most part this emerges in the second phase of the study that explores the perceptions of expert psychotherapists. As practice wisdom is generally beyond the range of human awareness, it is distinguished from propositional knowledge elicited in the first phase of that examines the meaning of expert practice based on the explicit understandings of psychotherapy trainers.

Although the findings of both phases are comprehensively reported, it is apparent that the reflections of expert practitioners reveal rich, "thick" (Denzin, 2001, p.98) descriptions of 'therapeutic know-how'. This contrasts with the relatively thin 'knowledge that' descriptions featuring in Phase I (Geertz, 1973). Indeed these trainer statements share much in common with Aristotle's notion of *techne*-oriented knowledge that pursues specific goals in rationalist positivistic terms. This is at odds with the comments of experts in the second phase of the study that highlight the complex dynamics of real-world therapeutic situations. In particular, their reflections embody Schön's (1987) notions of practitioner reflection-in-action and reflection-on-action as key determinants of effective psychotherapy.

In Phase II, tacit practitioner understandings are transformed into explicit notions through the process of reflexive praxis that manifests sophisticated knowledge regarding what makes therapy work. In contrast, Phase I themes resemble knowledge gleaned from *techne*-oriented empirical studies within psychotherapy. However to some extent this trainer knowledge is expanded by the influence of *phronesis* that facilitates enhanced understandings similar to those indicated in this study's second phase.

Although Aristotle (1976) introduces these two diverse forms of knowledge they are augmented and applied to practices of care in domains

of psychotherapy, counselling and social work. As indicated throughout this thesis, Polkinghorne (2004) claims effective praxis requires a knowledge model emphasizing the situated judgement of practitioners. This position advocates that praxis is comprised of a series of reflexive actions that affect change in varied realms of physical, organic, human and social experience. In view of this diversity, Polkinghorne argues each of these realms requires varied forms of practice to attain specified goals.

Drawing on tenets advocated by Dewey (1933) and Gadamer (1976), Polkinghorne (2004) articulates a model of human praxis incorporating reflective understanding, embodied reasoning and background interpretation. Together these elements facilitate deeper understandings of issues that confront individual practitioners of care. Accordingly, this encourages a greater level of insight and awareness towards the other and self.

In keeping with Aristotle's (1976) notion of phronesis, this study attempts to demonstrate its precepts inform the effective practice of expert psychotherapists. In essence, these understandings are featured in the overarching themes particularised in Chapters Four and Five. Indeed, a review of these outcomes indicates they comply with Polkinghorne's (2004) recommendations. These findings stress internalized, second-order client change, client and therapist contributions and overt and covert interpersonal processes manifesting within the therapeutic encounter are the determinants of effective psychotherapy. Furthermore these informants fall within Polkinghorne's understandings of practice wisdom as they emerge from the reflective consideration, embodied reasoning and background interpretations of practitioners of care.

Additionally, it is instructive to consider whether these outcomes fall within the ambit of practice wisdom identified by Confucius and articulated by Schwartz (2010) as reflection, imitation, and experience. Although this study determines reflection is highly valued by West Australian expert practitioners as an informant of effective therapy, trainer-participants in the first phase of the study limit its application to the cognitive domain of therapeutic mastery. Moreover, although imitation in the form of mentoring

and supervision is identified as a determinant of expert practice by Phase I trainers, these features are not recognized as informants of effective therapy by Phase II expert practitioners.

Whilst a number of explanations might elucidate this omission, perhaps a likely reason rests with the role of supervision and mentoring within the psychotherapy profession generally. As both these activities are commonly viewed as vital features of professional development, it is not surprising they are overlooked by master therapists exploring the subtleties of effective therapy. This argument is strengthened by the increased efforts of West Australian psychotherapeutic regulatory bodies to make supervision mandatory. Thus awareness of an obligatory practice is much more likely to fall within the realm of explicit knowledge. Accordingly, in keeping with this stance, trainer descriptions privileging the significance of supervision are much more probable. This contrasts with the procedural knowledge of experts seeking to explore more tacit phenomena.

Finally, as practitioner experience is not identified as an influence or feature of therapeutic expertise, experience appears to have a limited influence on therapeutic effectiveness. This is in keeping with consistent empirical research that indicates therapists with more experience are no more effective than less experienced therapists (Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Nietzel & Fisher, 1981; Smith & Glass, 1977). Thus in terms of the outcomes of this study, Polkinghorne's (2004) criteria of practice wisdom based on reflective understanding and embodied reasoning may be more pertinent than Confucian principles extolling experience articulated by Schwartz (2010).

In assessing the effect of Polkinghorne's (2004) reflections on phronesis, a final issue to be explored incorporates a practical outcome of this study. Although all overarching themes that emerged from the study are reviewed in previous chapters, a model of phronetic praxis developed in response to the findings of the study is presented in the remainder of this epilogue. It is contended this six-phased transtheoretical approach may enhance the effectiveness of psychotherapy. Although it fails to adopt

techne's empirical, rationalist, evidence-based precepts, it functions as an expression of practice wisdom in-action.

Accordingly, the final task of this research introduces this six-phased model in the form of a 'grand' reflection by the researcher informed by her dual roles as research inquirer and psychotherapeutic practitioner. As this takes the form of phronetic practice-in and on-action it is presented in the first person in an effort to reveal the curative potential of practice wisdom.

A 'Grand' Reflection on What Makes Therapy Work

As a psychotherapeutic practitioner of fifteen years standing, I began this research from a very personal perspective. I was faintly aware of the incongruity between my ideas of what worked in therapy and existing empirical inquiries that examined this question. Although I viewed myself as an eclectic practitioner with an interest in psychoanalytic ideas and Rogerian ways of working, I came to the view that I was principally informed by the personal therapy and mentoring I received in my years of my practice. These influences led me to undertake research that explored the critical analysis, reflexivity, insight and clinical rigour of master therapists. Thus, I now find myself in the position of advancing a model of therapeutic praxis based on the practice wisdom of the nine expert practitioners who participated in Phase II of this study. With this in mind I wish to present a process model based on their understandings as a contribution to this knowledge domain. Additionally, in deference to the invaluable influence of Aristotle (1976) and Polkinghorne (1983), I coin this model the six 'C's' of practice wisdom and present an account of its individual phases and their effect.

A Model of Phronetic Process: The Six 'C's' of Psychotherapy

This model of praxis wisdom provides a sequentially phased approach to facilitating beneficial psychotherapeutic processes and outcomes. Although this construct emerged from this study, it is based on the understanding that the unique circumstances of specific situations govern its application. Essentially, it embodies a holistic synthesis that links research material drawn from this study with the informed literature. It

reflects a constructivist epistemology that views psychotherapeutic process from a relational perspective. This is mediated by client and therapist intrapsychic and interpersonal dynamics within the therapeutic dyad and the explicit and implicit space-between these parties. However, although the process dynamics that characterize this movement operate at an intrapsychic level, the model is primarily concerned with the interpersonal patterns of connection that take place at verbal and non-verbal levels within the therapeutic environment.

Although six distinct levels of relating are identified, they are not linear or reductionist in application. Even though each phase of the model emerges in chronological sequence directed by the situational needs of the parties, the on-going impact of each level is dynamic, non-linear, multi-dimensional and iterative. Each stage of the model is an implicit relational process driven by the changing circumstances of the therapeutic dyad.

Six interpersonal processes are identified commencing with a conversation that aims at therapeutic healing. Over time this dynamic develops into a mutual connection between the parties, advanced by ongoing collaboration, containment and challenge. Eventually, this cumulative process leads to curative change informed by client personal theories of change. Although this process centers on effecting change within the interiority of clients, therapists also experience change although this is substantially different to that experienced by clients. As each of these processes represents an evolving phase of any in-depth therapeutic encounter, the final task of this thesis examines the meaning and function of each of these processes.

Conversation

In the second phase of this study, expert participants stress that therapeutic success is largely determined by a mutually beneficial 'as if' relationship (Whelan, 1992) that takes the form of a conversation. Moreover, as indicated previously, the Phase II research population emphasizes that although clients are the primary focus of this encounter, both parties benefit. As the notion of a 'healing conversation' (Symington,

2006) is central to participant reflections, the next task of this discussion examines this construct.

Goolishian and Anderson (1987) state the notion of a therapeutic conversation is an apt description for exchanges between clients and therapists, distinguishing interviews or consultations as phenomena that fail to capture the essence of the therapeutic encounter. They argue the latter imply that something is done *to* clients rather than *with* them. Moreover interviews or consultations are inaccurate descriptions of psychotherapy, as a nonjudgmental, collaborative process that encourages maximum client involvement. Indeed the defining trait of a conversation is prefaced on the understanding that client and therapist engage in an oral exchange of sentiments, observations, opinions or ideas (Duncan, Hubble & Miller, 1997). Subsequently, this process enlists clients in the exploration of possibilities that define therapy as an intimately interpersonal event committed to client goals (Duncan & Miller, 2000).

As previously stated the notion of a conversation is also extended further by Symington's (2006) view that psychotherapy encompasses the notion of a conversation that is curative in and of itself. This is prefaced on the belief it is possible to resolve a problem merely through speaking to another therapeutic other. In clarifying this perspective, Symington highlights the inchoate human need 'to be with another' for the purpose of alleviating anguish in a very specific way. Based on Bion's (1977) synthesis, Symington makes the point that clients rarely know why they seek therapy even though they are aware they are troubled. Thus, in this context, communication is thought to illuminate the darkness that underpins personal despair.

Yet Symington (2006) stresses client difficulties are not alleviated by the therapist act of imparting knowledge. Rather, he postulates relief stems from a conversation per se that is restorative. Indeed the master therapists who took part in this study postulate this process of a healing conversation fosters awareness with regard to the nature of client problems and their underlying cause. Phase II also contends this usually occurs when perceptions of their difficulties are transformed from implicit to explicit

knowledge. In keeping with this ethos Eaton (1998) asserts psychotherapy achieves results, not by disentangling the real, but by providing clients with opportunities for the discovery of new meanings that reconfigure problems. Hence old facts are reframed in terms of new interpretations that lend themselves to more fruitful forms of social and personal action. Goolishian's (1990, p. 4) eloquent reflections on the nature of psychotherapy as a dialogical process are instructive:

Change in therapy is the dialogical creation of new narrative and therefore the opening of opportunity for new agency. The transformational power of narrative rests in its capacity to re-relate the events of our lives in the context of new and different meaning.

In an alternative stance Duncan and Miller (2000) posit the therapeutic endeavour centers on therapist efforts to transform client implicit perspectives into explicit understandings that bring curative effects. In particular, Duncan and Miller entreat therapists to highlight client ideas by focusing on their lead regarding the content of therapeutic conversations. Indeed, they suggest therapy begins with an invitation to clients to tell their stories. Accordingly, in the course of this process, therapists facilitate the unfolding of client experiences as experts on their lives:

The heroes, heroines, villains, and plot lines are revealed as clients tell the comedies, tragedies, and triumphs of their lives. This adventure story sets the content parameters of the therapist's questions. The therapist learns and converses in the client's language because the words the client uses represent an edited commentary of the client's view of life. Clients are novelists who carefully choose words to convey their story in a specific light (p. 179).

In providing guidance as to the content of these healing conversations, Gold (1994) suggests therapist questions remain within the frame of client content. However, these efforts gradually add to existing understandings as the therapeutic process deepens. As these questions impose minimal

therapist content, they provide opportunities for clients to find new meanings. Furthermore, Duncan and Miller (2000) stress therapist questions are designed to elicit verbal and non-verbal reactions to the specific concerns that clients bring to therapy. As a result candid exchanges between client and therapist result in a collaborative formulation. In addition, the parties identify relevant procedures that respond to established criteria to attain successful resolution of client difficulties. During this process client judgments of their life experience emerge as potent informants of therapeutic conversations.

However, although client subjectivity is respected, therapists are also viewed as active participants who contribute valuable ideas to the conversation. This input may evolve in two directions: a meaningful dialogue between the parties, or alternatively, fade away due to lack of active responses. Hence, studious attention to client reactions to therapist-generated content provides guidance in this mutual endeavour. Specifically, client enthusiasm for therapist ideas informs the developing conversation. Therapist monitoring of moment-to-moment experience that enhance client participation also mediates this process. Verification questions that address the meaning of the conversation ensure the appropriateness of discussions. Thus, this therapeutic thrust combines client perception with emergent psychotherapeutic ideas to form a theory of change that captures specific client circumstances (Bohart, 2000b). Essentially, this conversation provides an opportunity to uncover and construct a personal theory of change that exists within clients. As this evolves the therapeutic journey becomes fully realized in its final phase as client theories of change are recognised as the closing enactment of practice wisdom in this context. This change process is explored later in this chapter.

Connection

The second phase of this model of practice wisdom addresses the process of client/therapist interpersonal connection, also described as 'contact' (Erskine, Moursund & Trautmann, 1999). Most Phase II experts stress that individuals yearn for connection throughout the lifespan

spending much of their lives moving towards this state of 'being with another'.

To some extent this ethos reflects the relational turn in psychotherapy exemplified in the development of therapeutic modalities such as relational cultural theory (Jordan, 2004) and intersubjective psychotherapy (Atwood & Stolorow, 1984). Generally speaking, these theories postulate the drive for contact is central to psychological well-being as people grow in, through and towards connection. A variety of theorists maintain these dynamics manifest as expressions of mutual empathy, mutual responsiveness and mutual contribution that encourage individual and relational growth (Jordan Kaplan., Miller, Stiver & Surrey, 1991). Moreover, as the source of much human suffering stems from chronic isolation, the desire for connection is paramount. Although a variety of theories explain this alienation in diverse ways, each has a similar effect. Essentially, they posit that individuals often fail to represent themselves authentically in life so their real experience is unacknowledged. Consequently, a sense of isolation, immobilization, self-blame, and relational incompetence develops that interfere with the capacity to be productive and creative. Hence individuals seek therapeutic support as a response to this disconnection (Bondi, 2005).

This drive for connection is described by a range of theories that instruct therapists on appropriate responses. One perspective raised by Phase II experts stems from Siegel's (1999) notion of contingent connection and communication. Specifically, Siegel posits that as therapist and client commence the process of relating, one member of this dyad communicates to the other in verbal and non-verbal signals. This is realized through facial expressions, body movement gestures, tone of voice, timing and degree of intensity. Accordingly, the individual who receives a signal is required to recognize and interpret it correctly before sending a signal back to the initiator of the communication. When this occurs both parties feel understood enabling the process to continue. Accordingly, this becomes the basis of healthy, collaborative connection.

Within the context of psychotherapy, Siegel (1999) posits contact between therapist and client generally occurs at a non-verbal level (Schoore, 2009). Thus therapists watch for signals described as a 'right brain to right brain affect regulation'. Accordingly therapists are required to interpret these signals and respond to them appropriately. Alternatively, Stern (2004) refers to 'now' moments and 'moments of meeting' as exemplars of connection that impact on client/therapist relating. These are flashes of interaction that possess rich potential for change within the client, the therapeutic relationship and the therapist as well.

Collaboration

The third phase of this theory of practice wisdom addresses the collaborative process between client and therapist. All participants in the second phase of this study stressed the significance of client/therapist collaborative behaviours. In reflections that address the determinants of effective therapy, all expert participants view clients as active self-healers. They are viewed as powerful co-collaborators in the therapeutic enterprise, responding to therapist input by modifying resource to their advantage. Essentially, these participants claim therapist contributions join with complex, active intelligent systems of clients to resolve the latter's difficulties.

In an authoritative contribution that examines what makes therapy work, Horvath and Bedi (2002) place the collaborative relationship between client and therapist at the center of the therapeutic endeavour. Nevertheless, despite the thrust of this study, Bohart (2000a) makes the point this view of therapy is frequently obscured by the medical model's emphasis on the 'power over' stance of therapists that typifies rationalist concerns. This dominance of the therapist's role advanced by the medical model parallels McLeod's (1998) authoritative critique of this approach that ignores client contribution. Specifically, McLeod postulates that as clients are rarely asked to consider what makes therapy work, their omission is purposive and intentional. Accordingly, he maintains this dearth of exploration stems from socio-cultural mores that characterize professional psychotherapy (Gordon, 2000). In particular, McLeod argues that strong

institutional pressures encourage researchers to adopt the assumptions and practices of natural science, described by this research as the logos of techne. These contextual pressures promote approaches to research characterised by positivistic, rationalist ideas that value reliable objective measures. These are derived from theories and models used to create controlled experimental conditions that have the capacity to test hypotheses. However as McLeod contends this perspective discounts client subjective feelings, states of mind or beliefs as legitimate topics of interest. This position is at odds with the constructivist stance of phronesis that underpins this study. .

The Container/Contained

The fourth process identified by this model focuses on the container/contained relationship between client and therapist. This stems from an overriding premise of Phase II expert participants who centre on the importance of therapist containment of clients. Indeed this is viewed as a key feature of the therapeutic encounter that impacts on effectiveness regardless of choice of modality. Although the notion of the contained/contained derives from psychoanalytic theory, its use is becoming more generalized within a broader therapeutic discourse (Renolds, 2007).

The process of containment within the analytic tradition refers to the management of another person's difficult feelings that are uncontained (Casement, 1992). Hinshelwood (1989) describes this as a decisive concept that retains close links to Klein's (1946) concept of projective identification "in which one person in some sense contains a part of another" (Hinshelwood, p. 246). Additionally Miller-Pietroni (1999) asserts containment embodies a powerfully felt, active and interactive process that involves the shedding and projection of internal parts. As these are viewed as damaged, frightening phenomena they are placed inside another for the purpose of psychosomatic containment. Whilst Freud (1912) lays the theoretical groundwork that underpins containment, Bion's (1962) container/contained relationship constitutes the basis of contemporary thought that addresses this notion.

Essentially, Bion (1962) prefaces the container/contained relational process on the model of the mother as a container for her infant's projected needs, feelings and unwanted parts. A defining feature of 'the contained' constitutes that part of the infant that has not reached a verbal state of development or, alternatively has burst the capacity of words to contain meaning. To demonstrate its operation, Bion offers the example of the verbal stammer that occurs when emotion disrupts containing words and grammar. In describing this process in the context of the mother/child dyad, the 'containing other' receives pre-verbal raw material and then activates a reflective, psychosomatic process that enables psychic digestion to occur. This is generally a precursor to development of physical awareness of this event. Furthermore, the process of understanding the nature of the material being contained requires emotional labour of a profound psychosomatic kind. Indeed, Bion points out that containment involves much more than simply listening to another.

In applying Bion's (1962) ideas to the domain of psychotherapy, the client, like the infant, tries to get rid of unwanted, uncomfortable parts of themselves by projecting these phenomena psychically into the therapist through the mechanism of projective identification. Thus this material is contained in the inner space of the therapist where it is felt long before it is physically recognized. This process of containing inchoate, primitive material is known as introjective identification. In effect, something is overtly or covertly pushed into the therapist container, who carries and is changed by it. Moreover, observation and reflection on the part of the therapist determine what unwanted part of the self can become consciously articulated and reintegrated by the client at a later time.

Therefore, containing may be likened to a process of psychic digestion in which the container's senses receive and examine what has been projected prior to the emotional and cognitive task of separating what is psychologically toxic from what is psychologically useful. Bion uses the term 'reverie' to describe the calm, receptive state of mind required of the containing therapist who makes sense of what has been projected. The container, in a state of reverie, identifies with the material that has been

taken in at a primitive psychosomatic level and then begins to try to understand it, before detoxifying its more alarming aspects until the modified contents may be returned in a safer and more tolerable form.

Challenge

The majority of expert therapists in the study reflect on the importance of challenging client unhelpful cognitions, affects and behaviours as essential steps in facilitating change. As stressed previously, the majority of processes that constitute this model of phronesis function at an implicit level of awareness, however the therapeutic challenge falls within the domain of explicit understandings. Although the importance of challenge is not emphasized in the literature, the notion of confrontation is given substantive attention. Thus the next task of this commentary investigates the praxis of confrontation with specific attention to empathic confrontation as it shares much in common with the therapeutic challenge.

Like the container/contained, the role of confrontation in psychotherapy is examined extensively in the psychoanalytic literature. Myerson (1973) views confrontation as an intervention that aims to effect change in clients where resistance is encountered, whilst Mann (1973) views confrontation as a mode of teaching. Greenson (1967) describes this notion as one of four essential procedures in psychoanalysis. These include clarification, interpretation, and the working through of dysfunctional ingrained behaviours. In the main these references refer to traditional forms of confrontation that Corwin (1973, p. 73) names "heroic confrontation". In general this is an emotionally charged encounter that seeks to overcome some form of therapeutic impasse that is damaging to the working alliance or clients. Essentially, the heroic encounter aims to mobilize the client into taking action with regard to a situation that is experienced as acute or chronic.

Nevertheless, although this form of therapist response may be necessary, the literature indicates therapists are generally extremely reluctant to incorporate this process. This is unfortunate as the need for action may be essential due to the presence of client or therapist danger,

out of control client behaviours or self-sabotage. Although the reasons for this disinclination are contextually-driven, they generally stem from countertransference difficulties or simple concern that the confrontation will be misunderstood (Comstock, 1991). Accordingly, the psychoanalytic literature underscores the notion of empathic confrontation as an alternative process that is effective in helping clients move in directions that are positive and therapeutically sound.

Within the psychoanalytic literature Welpton (1973, p. 266) provides a clear description of empathic confrontation as a process in which therapists work towards understanding, accepting and empathizing with clients as fully as possible. This involves bringing full attention to client blocks and inferences and unpacking these difficulties with clients to attain deep, mutual understandings of their causes and effects. Chu (1992) submits that when therapists invoke confrontations they are required to be enacted as empathically as possible. In this way, the working alliance is strengthened moving clients into more collaborative, mutual positions within the therapeutic relationship. As Mann (1973, p.44) notes:

the gentle, caring concern of the therapist for the patient may well be the most important element in a proper, effective confrontation....It communicates to the patient his privilege to choose the direction that he would like to move in rather than communicating a directive to which the patient feels impelled to yield.

Although the psychoanalytic literature describes the nature of this process as a confrontation, it is suggested that a pan theoretical approach be applied to this dynamic within the context of this study in terms of the research material it has elicited. Specifically, this suggestion stems from the fact that most of the discussions that emerge from this study refer to therapist 'confrontations' as therapist 'challenges' that aim to ameliorate client destructive behaviours. Moreover, as the expert research population that authored this material represents diverse forms of depth therapies that support empathic, relational methods, it is suggested that the term challenge is more contextually appropriate than confrontation.

This approach also has support within the general psychotherapeutic literature as indicated by Egan (2007) who uses the term challenge in lieu of confrontation. Indeed, Egan proposes the notion of a challenge implies the presence of constructive, growth-directed feedback that is positive in context and intent. Contrarily, he contrasts the pejorative features of a confrontation viewed as critical and disappointing. Indeed, Ivey and Ivey (2007) refer to therapeutic challenges as gentle skills that involve listening to clients, carefully and respectfully, and then seeking to help them examine themselves, or a situation more fully..."it is not going against the client, it is going with the client" (p.263).

Client theory of change

As indicated in the first phase of this process model, a number of psychotherapeutic theorists (Duncan & Miller, 2000; Gold, 1994; Held, 1991) consider clients engaged in therapy are in charge of the content of their lives, whilst therapists are in charge of the process that explores this content. Accordingly, these authorities argue this process takes place at explicit and implicit levels of awareness. Thus this unfolding, illumination and understanding opens the doorway to client change. Indeed, Duncan and Miller (2000) submit clients hold uniquely personal theories of change that are waiting to be discovered. Hence they assert a framework of therapeutic interventions is needed to uncover and make use of these resources. With this in mind Duncan and Miller postulate therapists are required to "seek a pristine understanding of a close encounter with the client's unique interpretations and cultural experiences" (p.180). In other words, therapists are encouraged to listen and learn their clients' theories of change as necessary aspects of any intervention.

Initially Duncan and Miller (2000) assert this begins when therapists listen closely to client language that enhances their capacity to use client phrases in appropriate reframes throughout the therapeutic endeavour. This practice is thought to privilege client idiosyncratic understandings by conveying the importance of their ideas and participation. Additionally, therapists are prompted to make direct inquiries about client goals that include ideas about appropriate interventions. Duncan and Miller make the

point that clients possess all the necessary ingredients to resolve these difficulties together with the ability to elucidate the attainment of this objective. Furthermore, they suggest therapist questions validating client hunches are likely to encourage client participation. Consequently this provides direct access to client theories of change.

Gold (1994) suggests it is helpful inquire about the usual way in which clients deal with change as the credibility of therapeutic process is enhanced when linked to previously successful experience of client change. Finally, discussion of prior solutions also provides methods for learning preferred client strategies. This exploration of previous client efforts enables therapists to match therapeutic interventions elements clients consider to be useful. However focusing on client perspectives does not prevent therapists from contributing to the construction of the client's theory of change. The discovery of client theories of change is a collaborative process that generates a seamless connection of socially constructed meanings. Therapist input is varied as it is informed by client expectations of the therapist's role.

Honouring the client's theory of change occurs when a therapeutic procedure complements pre-existing client beliefs about their problems and the change process. This manifests as therapists listen to client stories, amplifying experiences and interpretations that clients offer about their problems. This includes exploration of client thoughts, feelings, and ideas about how those problems might be best addressed. As this process evolves, therapists gradually implement client solutions they consider workable. Alternatively, they seek to ratify their own positions that match client theories promoting possibilities for beneficial change.

In summary, incorporating client theories of change implies that the maps clients provide function as beneficial guides to the therapeutic territory. In this context therapists are viewed as co-adventurers who explore a variety of landscapes from numerous vantage points as they cross the terrain of client theories of change. From time to time when difficulties occur, clients combine with therapists to seek alternate routes through therapist maps. However, during this process both parties often uncover

new, unknown trails. This approach contrasts with the traditional view of psychotherapy that views clients as playing the “nameless, faceless parts in therapeutic change” (Duncan & Miller, 2000, p. 185). Alternatively, honouring client theories of change represents proactive initiatives that call for therapy to be conducted in the context of client circumstances, beliefs and ideas. This is very different from the medical model of *techne* that currently prevails.

Final Word

Having presented this model of practice wisdom as the final act celebrating psychotherapeutic understandings informed by *phronesis*, this explication concludes with the last paragraph of the latest offerings by Duncan et al., (2010). This decision is intentional as the authoritative investigations of these vanguard researchers represent the latest critique of *techne* and *phronesis* inquiry regarding what makes therapy work.

In summing up their latest volume, these authors privilege formal monitoring of client feedback as developments most likely to elucidate further informants of effective therapy. Although these recommendations highlight the significance of rationalist, quantitative measures as the primary means of gleaning research data, their focus on local client knowledge is encouraging. Specifically, their emphasis on clients as “heroic characters” in the “drama of mental health” (Duncan & Miller, 2000, p. 171) is likely to offer profound insights in a future program of large-scale contextual outcome research. Although this thesis focuses on the tapping of practitioner wisdom gleaned from a qualitative perspective, it is submitted the domain of client understandings regarding the informants of effective therapy also represents a promising opportunity for future exploration. However broader methods of investigation that include constructivist, phenomenological understandings of clients are also envisaged by Duncan and Miller. Thus, in keeping with this ethos, their sentiments are pertinent to the final words of this research:

We concede that the pull toward the old paradigm is strong. The medical model for psychotherapy remains robust, and its reach into

every aspect of clinical work is deep. To move beyond it, to accept it and then put to use the latest science, will require nothing short of a paradigmatic shift. Such a change naturally, will take time, in combination with strong and consistent leadership (p.428).

Epilogue Schematic Outline (Part C)

Exemplar of Practice Wisdom

Six 'C' Process Model of Effective Therapy

- i. Collaborative conversations of master therapists and researcher in Phase II gleaned grounded theory characterizing series of emergent themes
 - Led to development of process model of effective therapy coined Six 'C' Process Model of Effective Therapy
 - Form of phronesis derived from wisdom of expert reflection
 - Parallel process adopted by researcher in identifying thesis themes
- ii. Six 'C' Process Model of Effective Therapy
 - Trans-theoretical model applied to any therapeutic context regardless of modality
 - Presented as "Grand Reflection" to conclude thesis
- iii. Features of Six 'C' Process Model capturing tacit knowledge that informs effective therapy
 - Conversation
 - Connection
 - Collaboration
 - Containment
 - Challenge
 - Client Change Theory
- iv. Phronetic model in its infancy - requires further development and informed research

APPENDIX 'A'

PHASE ONE: MEANING OF EXPERT PSYCHOTHERAPY LETTER OF INTRODUCTION TO PSYCHOTHERAPY TRAINERS & EDUCATORS

My name is Dhyan Stein and I am currently enrolled in a PhD program by research in the School of Psychology at Curtin University of Technology in Western Australia. This investigation aims to examine 'what makes psychotherapy work' based on the understandings of practitioners viewed as 'experts' in their field. As I am aware you are trainer and educator in psychotherapy I ask for your assistance with respect to this project.

In particular I am keen to explore your perceptions regarding the meaning and informants of therapeutic expertise. To obtain this research material I would appreciate the opportunity of meeting with you for a sixty minute discussion at a time and place of your convenience. With your consent, this conversation would be recorded on audiotape for the purpose of transcription and analysis. As a part of this process you will also be asked to identify three local psychotherapists you consider to be expert practitioners. This task will be undertaken by a 'blind' nomination process to ensure your identity and those you nominate cannot be known, linked or made public in any way. In addition, all research material provided by you will be treated as strictly private, anonymous and confidential. However, although this inquiry conforms to ethical research standards to the best of my ability, I wish to advise you that you may withdraw from the study at any time for whatever reason.

I hope you will agree to participate as I believe the study may contribute to the advancement of psychotherapeutic education and praxis within Western Australia. Accordingly, I will contact you by telephone within the next fortnight to ascertain your response to this request. However should you have any queries I may be contacted by email at d.stein@curtin.edu.au. Alternatively you may wish to contact Dr Brian Bishop, the principal supervisor of this study at b.bishop@curtin.edu.au

Yours faithfully

Dhyan Stein

APPENDIX 'B'

PHASE ONE: CONFIRMATION ADVICE & INFORMED CONSENT FORM

Thank you for agreeing to participate in this study. Your efforts are greatly appreciated. This letter, confirming the details we discussed in our recent telephone conversation, clarifies the purpose of the research, the selection criteria of the research populations involved and the various phases of the study. In addition an informed consent form is attached for your perusal. You will be asked to sign a copy of this document prior to the commencement of this investigation, after all our concerns are satisfied

Purpose of the research:

Primarily this study seeks to understand the determinants of effective psychotherapy from the perceptions of psychotherapeutic practitioners in Western Australia identified as 'experts' in their field. Although this goal dominates the study in its second phase, the first phase of this inquiry is also important. This centers on exploring the understandings of West Australian trainers and educators regarding the qualities and informants of psychotherapeutic expertise. An additional aspect of this first phase involves a confidential 'blind' nomination process. Essentially this means that all trainers and educators who participate in the first phase are asked to identify three West Australian psychotherapists currently engaged in practice whom they consider to be expert in their field. To ensure anonymity and confidentiality, this procedure is designed to ensure that any identifying links between nominator and nominee are removed.

Selection Criteria:

Phase One:

Psychotherapeutic trainers and educators who participate in the study are selected from two sources. Initially they are identified from internet searches of the public domain. Secondly, on completion of each interview, participants are asked to identify colleagues who meet the criteria and may be interested in participation. Accordingly letters of introduction are forwarded to these individuals.

Phase Two:

Psychotherapeutic practitioners in the domains of applied psychology, clinical and counselling psychology, psychiatry, social work, health and human services are contacted for participation in Phase Two of this study. Eligibility for participation is determined by compliance with at least one of the following categories:

- Psychologists providing services registered in keeping with the statutory requirements of the Psychologist Board of Western Australia and/or practitioners registered with specialist titles of clinical psychologist and counselling psychologist;

- Medical practitioners registered by the Medical Board of Western Australia who are members of the Royal Australian and New Zealand College of Psychiatrists;
- Social workers eligible to practice psychotherapy as 'mental health workers' in accord with the requirements of the Australian Association of Social Workers;
- Psychotherapists and counsellors who have attained undergraduate or post-graduate tertiary qualifications and are eligible for full membership of the Psychotherapy and Counselling Federation of Australia;

And

- Those psychotherapeutic practitioners identified as experts in their field by the 'blind' nomination process undertaken in the first phase of the study.

Risks:

It is not anticipated that participation in this study will lead to personal distress. However, if informants experience difficulties they will, with their permission, be referred to Dr Brian Bishop, the principal supervisor of this project.

Benefits:

The consequences of this project have significant value for psychotherapeutic praxis as the study seeks to identify what 'makes therapy work'. This constitutes tapping both the explicit knowledge of practitioners as well as their procedural knowledge. The latter takes the form of implicit and tacit understandings that are normally beyond the range of human awareness. As this form of practice-based inquiry is challenging and relatively rare it is likely to make a contribution to the development of new knowledge within psychotherapeutic domain.

Confidentiality/Protection of Identity:

Confidentiality of information and protection of participant identity are protected at all times. The following procedures are followed to ensure this:

- Conversations will be recorded, de-identified and transcribed by the researcher personally unless express permission for the use of an assistant is given;
- Should transcription assistance be sought all knowledge of informants will be de-identified;
- De-identification of all research material will occur prior to discussion with supervisors;
- All tapes and transcripts of interviews will be de-identified and linked by code. These will be stored separately under lock and key in the School of Psychology at Curtin University of Technology;
- Access to this material will be limited to the researcher. Only de-identified research material will be made available to the project's supervisory team;

- All information reported in the final research report or presentation will be de-identified;
- Where risk of identification in any publication or presentation is possible, language will be modified to ensure anonymity;
- All peer nominations of expert psychotherapists will be submitted 'blind' and cannot be linked to any other research material.

Please note that all participants are free to withdraw from the process at any time without any fear of censure.

Participant Informed Consent Declaration:

I have read the above material and I am fully informed of the purpose of this research study, the manner of my participation and what will become of the information if I give my consent. This consent procedure allows me to know the nature of the research and any risks associated with participation. I am aware that my decision to participate or not participate is determined by a free and informed process. If I do give my consent I understand that it may be withdrawn at any stage without prejudice or adverse consequences.

Should the interviewer require the support of an assistant to help with transcription of the audiotape recorded in this interview, I do / do not give my consent to this arrangement.

I have read and understand the above information and I have had my questions regarding the research answered to my satisfaction. I understand that if I complete my participation in the project I am giving consent by implication.

Name: _____

Signed: _____

Date: _____

APPENDIX 'C'

PHASE ONE: 'EXPERT' NOMINATION FORM

You are requested to nominate three psychotherapists you consider to be expert practitioners in their field. Provision for nomination is made in the spaces below. You are requested to print your response.

Please remember your decision is based on your personal opinion and will remain **anonymous, confidential and de-identified** as steps have been taken to ensure that your response cannot be linked to you personally.

When you have completed the nomination kindly enclose this form in **the self addressed stamped envelope** provided and forward it by post as directed at your earliest convenience.

1. _____
2. _____
3. _____

APPENDIX 'D'

PHASE TWO: LETTER OF CONFIRMATION & INFORMED CONSENT FORM

Further to our telephone conversation I wish to formally confirm that you have been nominated as an expert psychotherapist by participants who formed the research population of the first phase of this study. Accordingly, I wish to advise you of the details of this research project and your potential involvement. In addition, I have enclosed an informed consent form that you will be asked to sign prior to commencement of the research process, after any concerns you may have are satisfied.

Purpose of the research:

Primarily this study seeks to understand the determinants of effective psychotherapy from the perceptions of psychotherapeutic practitioners in Western Australia identified as 'experts' in their field. Although this goal dominates the study in its second phase, the first phase of this inquiry is also important. This centers on exploring the understandings of West Australian trainers and educators regarding the qualities and informants of psychotherapeutic expertise. An additional aspect of this first phase involves a confidential 'blind' nomination process. Essentially this means that all trainers and educators who participate in the first phase are asked to identify three West Australian psychotherapists currently engaged in practice whom they consider to be expert in their field. To ensure anonymity and confidentiality, this procedure is designed to ensure that any identifying links between nominator and nominee are removed.

Selection Criteria:

Phase One:

Psychotherapeutic trainers and educators who participate in the study are selected from two sources. Initially they are identified from internet searches of the public domain. Secondly, on completion of each interview, participants are asked to identify colleagues who meet the criteria and may be interested in participation. Accordingly letters of introduction are forwarded to these individuals.

Phase Two:

Psychotherapeutic practitioners in the domains of applied psychology, clinical and counselling psychology, psychiatry, social work, health and human services are contacted for participation in Phase Two of this study. They will be asked to participate in at least three hourly interviews with the researcher that explores the qualities and informants of effective psychotherapeutic praxis. Eligibility for participation is determined by compliance with at least one of the following categories:

- Psychologists providing services registered in keeping with the statutory requirements of the Psychologist Board of Western Australia and/or practitioners registered with specialist titles of clinical psychologist and counselling psychologist;

- Medical practitioners registered by the Medical Board of Western Australia who are members of the Royal Australian and New Zealand College of Psychiatrists;
- Social workers eligible to practice psychotherapy as 'mental health workers' in accord with the requirements of the Australian Association of Social Workers;
- Psychotherapists and counsellors who have attained undergraduate or post-graduate tertiary qualifications and are eligible for full membership of the Psychotherapy and Counselling Federation of Australia;

And

- Those psychotherapeutic practitioners identified as experts in their field by the 'blind' nomination process undertaken in the first phase of the study.

Risks:

It is not anticipated that participation in this study will lead to personal distress. However, if informants experience difficulties they will, with their permission, be referred to Dr Brian Bishop, the principal supervisor of this project.

Benefits:

The consequences of this project have significant value for psychotherapeutic praxis as the study seeks to identify what 'makes therapy work'. This constitutes tapping both the explicit knowledge of practitioners as well as their procedural knowledge. The latter takes the form of implicit and tacit understandings that are normally beyond the range of human awareness. As this form of practice-based inquiry is challenging and relatively rare it is likely to make a contribution to the development of new knowledge within psychotherapeutic domain.

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- Conversations will be recorded, de-identified and transcribed by the researcher personally unless express permission for the use of an assistant is given;
- Should transcription assistance be sought all knowledge of informants will be de-identified;
- De-identification of all research material will occur prior to discussion with supervisors;
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- All peer nominations of expert psychotherapists will submitted 'blind' and cannot be linked to any other research material.

Please note that all participants are free to withdraw from the process at any time without any fear of censure.

Participant Informed Consent Declaration:

I have read the above material and I am fully informed of the purpose of this research study, the manner of my participation and what will become of the information if I give my consent. This consent procedure allows me to know the nature of the research and any risks associated with participation. I am aware that my decision to participate or not participate is determine by a free and informed process. If I do give my consent I understand that it may be withdrawn at any stage without prejudice or adverse consequences.

Should the interviewer require the support of an assistant to help with transcription of the audiotape recorded in this interview, I do / do not give my consent to this arrangement.

I have read and understand the above information and I have had my questions regarding the research answered to my satisfaction. I understand that if I complete my participation in the project I am giving consent by implication.

Name: _____

Signed: _____

Date: _____

APPENDIX 'E'

PHASE ONE: MEANING OF EXPERT PSYCHOTHERAPY PROMPTS FOR SEMI-STRUCTURED CONVERSATION

1. Can you tell me something of your qualifications, background and clinical experience?
2. What is your understanding of the term 'expert' in the context of psychotherapeutic practice?
3. What do you consider to be the qualities of an expert psychotherapist?
4. How do you think these qualities are acquired? What influences shape the attributes of an expert psychotherapist?
5. If there were a recipe for making an expert therapist what would you include?
6. Based on your experiences who are three counselling practitioners you consider to be expert practitioners? Don't name them verbally but write their names on the blank nomination form I handed you at the beginning of this conversation.
7. Without disclosing their identity could you explain why you have nominated these individuals? What attributes do they share? How are they different from each other?

PHASE TWO: DETERMINANTS OF EFFECTIVE PSYCHOTHERAPY PROMPTS FOR OPEN CONVERSATIONAL DISCUSSIONS

- Explore reasons why they were nominated as an expert psychotherapist
- Professional qualifications and family of origin details and how they inform psychotherapeutic practice
- Explore why they chose the praxis of psychotherapy as a profession
- What is the real purpose of psychotherapy?

- The meaning of effectiveness in the context of psychotherapy
- Explore the connection between effectiveness and change
- Role of therapist in bringing about change
- What personal and professional qualities do therapists bring?
- What aspects do experts consider most important in the psychotherapeutic meeting?
- What is the role of clients and their 'symptoms' or presenting problems in this process?
- What do clients bring to the therapeutic encounter?
- What is the function of the different modalities in psychotherapeutic discourse?
- Which modalities do they choose to practice from? Why?
- In terms of effectiveness, who are their heroes in the practice of psychotherapy? What informs this choice and how does it affect the way they, themselves practice?
- How important is the therapeutic relationship in the development of psychotherapeutic success?
- What features are the most influential and why?
- Explore as many vignettes as possible to discover the covert and overt processes that affect change within the therapeutic environment
- How are they as therapists affected by the dynamics that manifest within the therapeutic environment?
- Focus on the non-verbal aspects of the therapeutic encounter and what they mean in terms of client development

APPENDIX 'F'

PHASE ONE: REFLEXIVE JOURNAL OF MAJOR THEMES

WHO IS AN EXPERT?

APPLICATION OF NORTH AMERICAN MASTERY MODEL

- Mixture of experience, reflection and curiosity - COGNITIVE
- Theoretical understanding and clinical acumen - COGNITIVE
- Awareness of trial and error processes in therapy - COGNITIVE
- Awareness of personal and professional limitations - COGNITIVE
- Humility, curiosity, support yet also challenge self and others - RELATIONAL
- Reich's listening with the third ear; listens for subtle nuances - RELATIONAL
- Sophisticated empathic attunement - EMOTIONAL & RELATIONAL
- Avoidance of assumptions
- Sensitivity to client vulnerabilities - EMOTIONAL
- New view of client problem; objective re client subjectivity - COGNITIVE
- Deficits in childhood narcissistic needs enable heightened attunement - EMOTIONAL
- Wounding that sets them up to be highly attuned to others - RELATIONAL
- Highly skilled artisan - COGNITIVE
- Emotional wisdom - EMOTIONAL
- Commitment to emotional truth leads to realness in facing reality of subjective experience - RELATIONAL
- Sense of humour
- Real respect for human frailty that clients doing the best they can - RELATIONAL
- Preparedness to constantly examine oneself - ALL THREE DOMAINS
- Courage to speak the unspeakable - EMOTIONAL
- Not knowing stance - COGNITIVE
- Cognitive emotional knowledge, wisdom and attunement - ALL THREE
- Distinguishes between experience and skill - COGNITIVE
- Experience does not mean expertise or being an expert
- The wounded healer reveals how pain experienced and dealt with - EMOTIONAL

PHASE TWO: REFLEXIVE JOURNAL OF MAJOR THEMES

MEANING OF EFFECTIVENESS

- 1) Research findings prefaced on alternative paradigm
 - a) Constructivist assumptions - practice based knowledge (phronesis); counter to evidence based empirical medical model of techne - study indicates psychotherapy needs to 'hold' evidence based praxis as well as practice based research - need both in society but within human realm phronesis requires more 'airplay'
 - b) Phase Two focuses on tapping procedural knowledge of experts - implicit and tacit - therefore RCT's of techne are insufficient- this is

propositional knowledge alone - need more - differing discourse of 'knowledge how, knowledge that and knowledge of' - in this study mostly focus on 'how';

- c) This relativistic constructivist ontology and epistemology reflects researcher's subjective view of research - essentially inquiry is phenomenological. Thus findings are collaboratively determined by the intersubjectivity of researcher and participants

2) Internalized client change is evidence of therapeutic effectiveness: What is the meaning of change in this context?

- a) Demonstrated by presence of second-order change - first-order change is merely behavioural; participants as adherents of depth therapy dismiss this as superficial and does not fall within their understandings of effectiveness discourse;
- b) Enhanced sense of self is indicative of second-order client change - evidenced by enhanced client self-representation in the course of therapy - psychotherapy undertaken not because of symptom relief but because we want to grow;
- c) Presence of 'objective' and subjective change also implies effectiveness - but 'objective' indicates continued role of the medical model as dominant discourse- prefaced on the existence of an objective truth - at odds with constructivist, contextualist views: represents natural science rather than human science - illustrative of Aristotle's techne - cannot debunk this empiricalization but we need more than this single discourse - this is the rationale for the study;
- d) This subjective/objective dichotomy typifies the paradoxical tensions that run through psychotherapeutic theory and praxis symbolized by polarized, inconsistent notions of change and effectiveness.

3) Client role in contributing to effective therapy:

- a) Function of symptoms is important when reviewing this question- paradox of symptoms, effective therapy and change - symptoms are really the doorway to change- indicate that client really wants something different but is stuck- needs externalized help - symptoms bring attention to this unconscious client desire;
- b) Client psychological mindedness - client is intimately involved in the decision-making process - ability to comprehend causative factors that underlie behaviours and attitudes - ability to comprehend defense mechanisms and unconscious conflicts. The literature indicates definitional notions are complex; difficult to ascertain exactly how this affects client/therapist meeting
- c) Client reflexivity - masterful awareness of self; potential for insight; flow of energy that moves from agency to self-awareness and then back to agency in a reiterative cycle;
- d) Openness to change - affects effectiveness- this stance conflicts with the medical model that depicts clients as suffering from illness and disease - clients as actors who co-author their life scripts and co-direct their actions
- e) Receptivity - kinesthetic, sensual, physical, emotional and mental experience that is fully taken into one's being in a palpable and bodily way

- f) Readiness for change - attribute of cognitive behavioural therapies that privilege motivational interviewing;

4) Contribution of therapists

- a) Commitment to emotional truth but what is emotional truth? To seek and speak the truth i.e. emergence of mental growth - need for an awareness of an emotional experience
- b) Therapist authenticity - highly variable meanings; clichéd term; means realness and genuineness and admission of therapeutic mistakes; attempts "to be with" the thoughts and feelings of clients; generalized state of being that demonstrates congruency in ideals, values and actions towards self and others
- c) Relational awareness - relational turn in psychotherapy means authenticity takes on much more of an interpersonal thrust
- d) Therapeutic presence - variant notions - necessitates therapists bring the fullness of themselves to their interactions with clients and be willing to be touched and moved by them; three stages of transtheoretical presence - preparation phase; process phase; in-session experience phase; embodies a form of altered consciousness.
- e) Receptive listening - attuning emotionally, cognitively and bodily from different kinds of listening - listening with the third ear; evenly suspended attention; reverie; to eschew memory and desire.
- f) Participant observer stance - paradoxical thinking *with* clients whilst thinking *about* clients; highlights therapist move from the position of observer to participant and back to observer position in an iterative fashion
- g) Executive and caring function - duality of roles - need to take up both roles to be effective
- h) Therapist acumen - embodies competence, experience, reputation, warmth and openness; constitutes empathic understanding of another's viewpoint attained by passing through their defense barriers;

5) Effect of interpersonal processes on effectiveness

- a) Presence of relational depth - characterized by deep connectedness and intense engagement i.e. moments of meeting, therapists were totally present and available to clients; parties' mutuality, presence, realness and receptivity that manifest in 'moments of meeting'. Remaining discussion looks at the elements of relational depth'
- b) Element of relational depth - mutuality - reciprocal, mutual development is a key outcome of effective client/therapist connections; sub-theme of relational depth
- c) Element of relational depth - described as moments of meeting; implicit relational knowing;
- d) Moments of meeting - turning points; intersubjective contact; sense of aliveness and 'here and now' momentum
- e) Implicit relational knowing - "how we do things with others"; encompasses normal and pathological knowing that integrates affect, fantasy, behavioral and cognitive dimensions; feelings and attitudes that are flowing within therapist at a specific moment;
- f) Therapist/client realness; the paradoxical 'as if' relationship;
- g) Client/therapist receptivity - dyadically expanded state of consciousness

6) Significant events paradigm

- a) Significant in-session moment- both client and therapist move towards a deeper connection with self, other and the relational flow; specific healing moments in the interpersonal encounter between client and therapist.
 - b) Different varieties - therapeutic moments; dialogic moments; present moments; all make up "the world in a grain of sand";
 - c) Dialogic moments (Buber) & effective moments(Rogers) share common features - i) therapists and clients active participants in therapy so seek to meet each other mutually in therapy; ii) mutuality between clients and therapists occurs even though roles within the therapeutic relationship are unequal; iii) quality of mutuality lasts only for a few minutes or less; iv) moments of genuine mutuality facilitate client transformation; v) clients likely to experience effective and dialogic moments more frequently as their relationships with therapist become more mutual;
 - d) Therapeutic moments named in study similar to effective moments
 - e) Present moments (Stern)- these occur in therapy sessions as a series of encounters driven by desire for contact within the intersubjective field - low-level everyday drama; now moments and moments of meeting in this context are pivotal;
 - f) Vulnerable moments - opportunities seized by clients that enable them to contact aspects of themselves without resorting to usual defense strategies; both client and therapist are aware of a qualitative difference in relating, this heralds a new development encapsulated in a moment of mutual vulnerability.
 - g) Moments of heightened affect associated with internal conflict and personal dilemmas; transtheoretical push/pull dynamic
 - h) Tripartite model of empathic inquiry influential in these vulnerable moments - begins with empathic imagination, developed by empathic immersion and empathic attunement - the latter is most common;
 - i) Six phased model of practice wisdom - conversation, connection; containment, collaboration, challenge and client theory of change
- LIMITATIONS AND IMPLICATIONS
 - CRITIQUE OF CURRENT DOMINANT DISCOURSE

APPENDIX 'G'

PHASE TWO: EXPERT SUMMARY AUDIT

1) Therapist Attributes:

- a) Capacity to listen; cognitive & emotional intelligence; compassion; ability to tolerate complexity & refrain from simplistic solutions;
- b) Reflection on intra-psychic and interpersonal process in all relational contexts ; acknowledgement of dualities, polarities and paradoxes of human condition within and beyond professional domain; personal growth a core life motivation; engagement with personal & professional dilemmas an evolving frame inherent to ongoing reflexivity;
- c) Lasting effect of personal therapy - life-changing informant;

2) Theoretical Orientation:

- a) Initial training in British object relations & group relations reflective of modern and post-modern worldviews; currently influenced by international & Australian analytic contemporaries;
- b) Rationale for adopting this orientation - approach made sense of the human condition;

3) Personal Attributes Informing Professional Stance:

- a) Interest in unconscious early in life - supportive friend; always in the role of confidante and compassionate listener;
- b) Exploration of meaning-making life-long stimulus
 - i. Reflexivity stimulated by early mentoring
 - ii. Interest in literature & proclivity to listening & supporting others emerged in early development;

4) Tenets of Practice:

- a) Guiding principle - Bion's stance "to eschew memory and desire". This means to listen whilst assuming nothing;
- b) Subtly of therapist participant-observer stance; needs of client are primary yet keen awareness of therapist's personal process as a major therapeutic tool is what distinguishes the relational analytic approach;
- c) Contextual meaning of border/boundary continuum; viewed as evolving construct; boundaries flexible elastic containers whilst borders are rigid, immovable constraints; border/boundary continuum informed by changing contextual climate of interpersonal therapeutic encounter;
 - a. Borders = traditional fixed therapeutic frame e.g. Therapist patient connection a non-social professional relationship; session length "time Nazi" conditions;
 - b. Boundaries = supple constructs that join & separate; expandable end of spectrum promoting freedom of movement; boundary interpretations dependent on what is therapeutic e.g. Strategic self-disclosure may be required to model authenticity; technological mode of interaction Skype may be appropriate frame;

Example of elastic boundary leading to therapeutic opening:

- i. Informed by a collaborative 'power with' rather than authoritarian 'power over' stance; notions of authority & leadership influenced by cultural heritage, experiential history & group relations training; demonstrates capacity to confront personal and professional tensions and sit with complexity from a not-knowing stance;

5) The Task of Therapy:

- a) Primary focus - to define task of therapy and then monitor when and why you have moved from the task; vignettes demonstrate this feature (omitted due to confidentiality issues).

6) The Roles of the Therapist:

- a) Two separate functions enhance effectiveness;
 - i. Executive role = managing time, payment, appointments etc.; supports authority & leadership;
 - ii. Caring role = the art/science of therapy;
 - iii. Both roles work together to maximise therapeutic encounter; authority of executive function supports caring function "creates the space for the work to occur";
 - iv. Clinical vignettes illustrate nexus between issue of acknowledging significance of both roles and effectiveness (omitted due to confidentiality issues).

7) Interpretation of the Transference:

- a) Meaning of interpretation
- b) Meaning of transference
- c) Effect of interpreting transference - example of interpreting the transference and impact on effectiveness (omitted due to confidentiality issues).

8) Therapist Relatedness:

- a. Authenticity in relating
- b. Mutuality & reciprocity within relationship
- c. Defining and adhering to task of therapy
- d. Managing therapeutic boundaries;
- e. Fostering development of "good internal object" in the other;
- f. Professional attributes

Therapeutic features

- i. Must "have grappled with one's internal stuff"
- ii. Rogers necessary & sufficient conditions required but inadequate; more is required
 - a) The container
 - b) The 'as if relationship'
 - c) Commitment to and enactment of emotional truth; example of the need to be a real person committed to emotional truth.

9) The Space in Between

- a) Communication between the therapist and patient referred to as the space in-between; operates at overt & covert level; language at

overt level but 'meeting' at covert level; this connection impacts on effectiveness

10) Holding Tensions of Dynamic Processes

- a) Complexity of eschewing memory & desire whilst defining task of therapy; enactment of this subtlety a feature of effective therapy; demonstrates ability to hold 'not knowing stance' in the context of apparent paradoxes & contradictions; reflective of intricate dynamic process;

11) A 'healing conversation' between patient and therapist

- a) The core of effectiveness involve a healing conversation that demonstrates aspects of the 'as if' relationship; clinical vignettes omitted due to confidentiality and privacy considerations;

12) Therapist commitment to development of self-awareness

- a) Therapist deep understanding of themselves and their own dynamics & what is stirred up in the dynamic between the therapist and patient;
- b) Therapist's capacity to be courageous in facing truths enables patients to experience an externally benevolent observer that is internalized begins to evolve within them as their own benevolent internal object within them;
- c) Recognition that the dynamic of therapy is a relational, evolving, mutual, bi-directional process;

13) Major Curative factors

- a) Psychological mindedness of patient; capacity to symbolize and to reflect on experience;
- b) The qualities of the therapist;
- c) The space in between;
- d) The relationship - this is the foundation and cornerstone.

References

- Alexander, F. (1961). *The scope of psychoanalysis*. New York: Basic Books.
- Alexander, F., & French, T. M. (1946). *Psychoanalytic therapy*. New York: Ronald Press.
- Almond, R. (2003). The holding function of theory. *Journal of American Psychoanalytic Association*, 51, 131-154.
- Alvesson, M., & Skoldberg, K. (2000). *Reflexive methodology: New vistas for qualitative research*. London: Sage.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.
- Anchin, J. C. (2008). Pursuing a unifying paradigm for psychotherapy: Tasks, dialectical considerations, and bio-psychosocial systems meta-theory. *Journal of Psychotherapy Integration*, 18, 310-349.
- Anchor, K. N., & Smith, P. (1978). Is there a place for programmed instruction training in psychotherapy? *Psychological Reports*, 43, (3), 1003-1008.
- Anderson, M. (2005). Psychotherapy as ritual: Connecting the concrete with the symbolic. In R. Moodley & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 282-291). Thousand Oaks CA: Sage.
- Andrade, V. M. (2005). Affect and the therapeutic action in psychoanalysis. *International Journal of Psychoanalysis*, 86, 677-697.
- Andrews, G., & Harvey, R. (1981). Does psychotherapy benefit neurotic patients? *Archives of General Psychiatry*, 38(11), 1203-1208.
- Angus, L., Levitt, H., & Hardtke, K. (1999). The narrative processes coding system: Research applications and implications for psychotherapy practice. *Journal of Clinical Psychology*, 55, 1255-1270.
- Angus, L. E., Lewin, J., Bouffard, B., & Rotondi-Trevisan, D. (2004). "What's the story"? Working with narrative in experiential psychotherapy:

- Practice, theory, and research. In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and research* (pp. 87-101). Thousand Oaks, CA: Sage.
- Appelbaum, S. A. (1973). Psychological-mindedness: Word, concept and essence. *International Journal of Psycho-Analysis*, 54, 35-46.
- Appleton, J. (1997). Constructivism: A naturalistic methodology for nursing inquiry. *Advances in Nursing Science*, 20(2), 13-22.
- Aristotle, S. (1976). *The Nicomachean ethics* (J. A. K. Thomson, Trans.). London: Penguin.
- Arksey, H., & Knight, P. (1999). Interviewing for social scientists: An introductory resource with examples. Thousand Oaks, CA: Sage.
- Aron, L. (1991). The patient's experience of the analyst's subjectivity. *Psychoanalytic Dialogues*, 1, 29-51.
- Arksey, H., & Knight, P. (1999). Interviewing for social scientists: An introductory resource with examples. Thousand Oaks, CA: Sage.
- Arnold, E. G., Farber, B. A., & Geller, J. D. (2000). Changes in patients' self representation over the course of psychotherapy. *Journal of American Psychoanalytic Association*, 28, 449-466.
- Arnold, K. (2006). Reik's theory of psychoanalytic listening. *Psychoanalytic Psychology*, 23, 754-765.
- Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart & soul of change: What works in therapy* (pp. 23-55). Washington, D.C: American Psychological Association.
- Ashworth, P., Williams, C., & Blackburn, I. (1999). What becomes of cognitive therapy trainees? A survey of trainees' opinions and current clinical practice after postgraduate cognitive therapy training. *Behavioural and Cognitive Psychotherapy*, 27(3), 267-277.

- Atwood, G., & Stolorow, A. (1980). Psychoanalytic concepts and the representational world. *Psychoanalysis and Contemporary Thought*, 3, 26-290.
- Atwood, G. E., & Stolorow, R. D. (1984). *Structures of subjectivity: Explorations in psychoanalytic phenomenology*. Hillsdale, NJ: Analytic Press
- Aveline, M. (2006). Issues in psychotherapeutic research. In D. Loewenthal & D. Winter (Eds.), *What is psychotherapeutic research* (pp. 3-28). London: Karnac.
- Bacal, H. A. (1995). The essence of Kohut's work and the progress of self psychology. *Psychoanalytic Dialogues*, 5, 353-366.
- Bacal, H. A., & Newman, K. M. (1990). *Theories of objects relations: Bridges to self-psychology*. New York: Columbia University Press.
- Bachelor, A. (1988). How clients perceive therapist empathy: A content analysis of "received" empathy. *Psychotherapy: Theory, Research, Practice, Training*, 25(2), 227-240.
- Bachelor, A. (1995). Clients' perception of the therapeutic alliance: A qualitative analysis. *Journal of Counselling Psychology*, 42(3), 323-337.
- Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 133-178). Washington, DC: American Psychological Association.
- Bachrach, L. L. (1981). Continuity of care for chronic mental patients: A conceptual analysis. *American Journal of Psychiatry*, 138(11), 1449-1456.
- Baer, R. A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice*, 10(2), 125-143.
- Bakhtin, M. M. (1981). *The dialogic imagination*. Austin and London: University of Texas Press.

- Baldwin, M. (Ed.). (2000). *The use of self in therapy* (2nd ed.). London: The Haworth Press.
- Balint, M. (1979). The basic fault: Therapeutic aspects of regression. New York: Brunner/Mazel.
- Baltes, P. B., & Staudinger, U. M. (2000). Wisdom: A meta-heuristic pragmatic to orchestrate mind and virtue toward excellence. *American Psychologist*, 55, 122-136.
- Bandura, A. (2006). Toward a psychology of human agency. *Perspectives on Psychological Science*, 1, 164-180.
- Barker, S. L., Funk, S. C., & Houston, B. K. (1988). Psychological treatment versus nonspecific factors: A meta-analysis of conditions that engender comparable expectations for improvement. *Clinical Psychology Review*, 8, 579-594.
- Barkham, M. (1990). Research and individual therapy. In W. Dryden (Ed.), *Individual therapy: A handbook*. Milton Keynes: Open University.
- Barlow, D. H. (1996). Health care policy, psychotherapy research, and the future of psychotherapy. *American Psychologist*, 51, 1050-1058.
- Barrett-Lennard, G. T. (1964). The relationship inventory: Forms OS-M-64/OS-F-64 and MO-M-64/MO-F-64. New England, Armidale, New South Wales, Australia: University of New England.
- Barrett-Lennard, G. T. (1978). The relationship inventory: Later developments and applications. *JSAS Catalog of Selected Documents in Psychology*, 8(68), 55.
- Barrett-Lennard, G. T. (1986). The Relationship Inventory now: Issues and advances in theory, method and use. In L. S. Greenberg and W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (439-476). New York: Guilford.
- Barrett-Lennard, G. T. (1988). Listening. *Person-Centered Review*, 3, 410-425.

- Bateman, A., & Fonagy, P. (2004). Mentalization-based treatment of borderline personality disorder. *Journal of Personality Disorders*, 18(1), 36-51.
- Bateson, G. (2002). *Mind and nature. A necessary unit*. Cresskill, NJ: Hampton Press.
- Behrends, R. S., & Blatt, S. (1985). Internalization and psychological development throughout the life cycle. In A. J. Solnit, R. S. Eissler & P. B. Neubauer (Eds.), *The psychoanalytic study of the child* (pp. 11-38). New Haven, CT: Yale University Press.
- Behrens, J. T., & Smith, M. L. (1996). Data and data analysis. In D. C. Berliner & R. C. Calfee (Eds.), *Handbook of educational psychology* (pp. 945-989). New York: Simon & Schuster.
- Bennett, J. A. (1995). Methodological notes on empathy: Further considerations. *Advanced Nursing Science*, 18(1), 36-50.
- Bennett, R. H. (1998). The importance of tacit knowledge in strategic deliberations and decisions. *Management Decision*, 36(9), 589-597.
- Bennett-Levy, J. (2006). Therapist skills: A cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy*, 34, 57-78.
- Berger, L. S. (1996). Toward a non-Cartesian psychotherapeutic framework: Radical pragmatism as an alternative *Philosophy, Psychiatry, & Psychology* 3(3), 169-184.
- Berger, L.S. (2002) *Psychotherapy as praxis: Abandoning misapplied science*. Victoria, Canada: Trafford Press.
- Berger, P. L., & Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. Garden City, NY: Doubleday.
- Bergin, A. E. (1971). The evaluation of therapeutic outcome. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 217-270). New York: Wiley.
- Bergin, A. E., & Garfield, S. L. (Eds.). (1994). *Handbook of psychotherapy and behavior change* (4th ed.). New York: Wiley.

- Bergin, A. E., & Lambert, M. J. (1978). The evaluation of therapeutic outcomes. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behaviour change: An empirical analysis* (2nd ed., pp. 139-190). New York: Wiley.
- Bergman, B. (1967). Some issues and problems for the core conditions. *Ohio Symposium of Humanistic Education*. Ohio: Ohio University Press.
- Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of clinical supervision*. Boston: Pearson.
- Bernstein, R. (1983). Beyond objectivism and relativism: Science, hermeneutics and praxis. Philadelphia: University of Pennsylvania.
- Bernstein, R. J. (1971). *Praxis and action: Contemporary philosophies of human activity*. Philadelphia: University of Pennsylvania Press.
- Bernstein, R. J. (1976). *The restructuring of social and political theory*. Oxford: Basil Blackwell.
- Beutler, L. E. (1990). Introduction to the special series on advances in psychotherapy process research. *Journal of Consulting and Clinical Psychology*, 58(3), 263-264.
- Beutler, L. E., & Hill, C. E. (1992). Process and outcome research in the treatment of adult victims of childhood sexual abuse: Methodological issues. *Journal of Consulting and Clinical Psychology*, 60, 204-212.
- Beutler, L. E., Machado, P., & Neufeldt, S. (1994). Therapist variables. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behaviour change* (4th ed., pp. 229-269). New York: Wiley.
- Beutler, L. E., Moleiro, C., & Talebi, H. (2002). Resistance in psychotherapy: What conclusions are supported by research? *Journal of Clinical Psychology*, 58, 207-217.
- Beutler, L. E., Williams, R. E., Wakefield, P. J., & Entwistle, S. R. (1995). Bridging scientist and practitioner perspectives in clinical psychology. *American Psychologist*, 50, 984-994.

- Beutler, L.E. (2009). Making science matter in clinical practice: Redefining psychotherapy. *Clinical Psychology: Science and Practice*, 16(3), 301-317.
- Beutler, L., Malik, M., Alomohamed S., et al. (2004). Therapist variables In: Lambert, M., Ed., Bergin and Garfield's Handbook of psychotherapy and behaviour change (5th ed.) (227-306). New York: Wiley.
- Bien, T. H. (2004). Quantum change and psychotherapy. *Journal of Clinical Psychology*, 60(5), 493-501.
- Bilsbury, C., & Richman, A. (2002). A staging approach to measuring patient-centred subjective outcomes. *Acta Psychiatrica Scandanavia*, 106(Suppl. 414), 5-40.
- Bion, W. R. (1961). *Experiences in groups and other papers*. London: Tavistock Publications.
- Bion, W. R. (1962). A theory of thinking. *International Journal of Psychoanalysis*, 33, 306-310.
- Bion, W. R. (1963). *Elements of psycho-analysis*. London: William Heinemann.
- Bion, W. R. (1965). *Transformations*. London: William Heinemann.
- Bion, W. R. (1966). Catastrophic change. *Bulletin of British Psychoanalytical Society*, 5.
- Bion, W. R. (1967). *Second thoughts*. London: Heinemann.
- Bion, W. R. (1977). *Seven servants*. New York: Jason Aronson Inc.
- Bischoff, R. J., & McBride, A. (1996). Client perceptions of couples and family therapy. *American Journal of Family Therapy* 24(2), 117-128.
- Bishop, B. J. (2007). Methodology, values and quantitative world-views in qualitative research in community psychology. *Australian Community Psychologist*, 19(1), 9-18.
- Bishop, B. J., & Browne, A. L. (2007). Natural resources management methodology: Lessons for complex community settings. *Australian Community Psychologist*, 19(1), 124-136.

- Bishop, B. J., Sonn, C. C., Drew, N. M., & Contos, N. E. (2002). The evolution of epistemology and concepts in an iterative-generative reflective practice: The Importance of small differences *American Journal of Community Psychology*, 30(4), 493-510.
- Black, M. (1967). *Proceedings: Second nursing theory conference*. Paper presented at the Public Health Service, Kansas City.
- Blatt, S., Wiseman, H., Prince-Gibson, E., & Gatt, C. (1991). Object representations and change in clinical functioning. *Psychotherapy*, 28, 273-283.
- Blatt, S. J. (1998). Contributions of psychoanalysis to the understanding and treatment of depression. *Journal of the American Psychoanalytic Association*, 46, 723-752.
- Blatt, S. J., & Blass, R. B. (1990). Attachment and separateness: A dialectical model of the products and processes of development throughout the life cycle *Psychoanalytic Study of the Child*, 45, 107-127.
- Blatt, S. J., Sanislow, C. A., Zuroff, D. C., & Pilkonis, P. A. (1996). Characteristics of effective therapists: Further analyses of data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, 64(6), 1276-1284.
- Bleakley, A. (1999). From reflective practice to holistic reflexivity. *Studies in Higher Education*, 24(3), 315-330.
- Blocher, D. (2000). *The evolution of counseling psychology* New York: Springer.
- Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Berkeley: University of California Press.
- Bohan, J. S. (1990). Social constructionism and contextual history: An expanded approach to the history of psychology. *Teaching of Psychology*, 17(2), 82-90.

- Bohart, A. C. (2004). How do clients make empathy work? *Person Centered and Experiential Psychotherapies*, 3(2), 102-116.
- Bohart, A., & Greenberg, L. S. (Eds.). (1997). *Empathy reconsidered: New directions in psychotherapy*. Washington DC: American Psychological Association.
- Bohart, A., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington, DC: American Psychological Association.
- Bohart, A. C. (1999). Intuition and creativity in psychotherapy. *Journal of Constructivist Psychology*, 12(4), 287-311.
- Bohart, A. C. (2000a). The client is the most important common factor: Clients' self-healing capacities and psychotherapy *Journal of Psychotherapy Integration*, 10(2), 127-149.
- Bohart, A. C. (2000b). Paradigm clash: Empirically supported treatments versus empirically supported psychotherapy practice. *Psychotherapy Research*, 10(4), 488-493.
- Bohart, A. C., & Byock, G. (2005). Experiencing Carl Rogers from the client's point of view: A vicarious ethnographic investigation. *The Humanistic Psychologist*, 33(3).
- Bohart, A. C., Elliott, R., Greenberg, L. S., & Watson, J. C. (2002). Empathy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 89-108). London: Oxford University Press.
- Bohart, A. C., & House, R. (2008). Empirically supported/validated treatments as modernist ideology. In R. House & D. Loewenthal (Eds.), *Against and for CBT: Towards a constructive dialogue?* London: PCCS Books.
- Bohart, A. C., & Tallman, K. (1996). The active client: Therapy as self-help. *Journal of Humanistic Psychology*, 36(3), 7-30.

- Bohart, A. C., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington DC: American Psychological Association.
- Bohm, D. (1981). *Wholeness and the implicate order*. London. Routledge & Kegan Paul.
- Bolognini, S. (2004). Intrapsychic - interpsychic. *The International Journal of Psychoanalysis*, 85(2), 337-357.
- Bondi, L. (2005). Making connections and thinking through emotions: Between geography and psychotherapy. *Transactions of the Institute of British Geographers*, 30(4), 433-448.
- Book, H. (1988). Empathy: Misconceptions and misuses in psychotherapy *American Journal of Psychiatry*, 145, 420-424.
- Boston Process Change Study Group. (2010). *Change in psychotherapy: A unifying paradigm*. New York: W. W. Norton and Company.
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, 16(3), 252-260.
- Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. Horvath & L. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. 13-37). New York: Wiley.
- Borys, D. S., & Pope, K. S. (1989). Dual relationships between therapist and client: A national study of psychologists, psychiatrists, and social workers. *Professional Psychology: Research and Practice*, 20(5), 283-293.
- Botella, L., & Herrero, O. (2000). A relational constructivist approach to narrative therapy. *European Journal of Psychotherapy & Counselling*, 3(3), 407-418.
- Boud, D., Keogh, R., & Walker, D. (Eds.). (1985). *Reflection: Turning experience into learning*. London: Kogan Page.

- Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. London: Routledge.
- Bowles, G. (1983). Is Women's Studies an academic discipline? In G. Bowles, D. Duelli-Klein & R. Klein (Eds.), *Theories of women's studies* (pp. 32-45). London: Routledge.
- Bozarth, J. D. (1997). Empathy from the framework of client-centered theory and the Rogerian hypothesis. In A. Bohart & L. Greenburg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 81-102). Washington D. C.: American Psychological Association
- Bozarth, J. D. (1998). *The person-centered approach: A revolutionary paradigm*. Ross-On-Wye, England PCCS Books
- Bracke, P. E., & Bugental, J. F. T. (2002). Existential/humanistic psychotherapy In F. W. Kaslow & R. F. Massey (Eds.), *Comprehensive handbook of psychotherapy: Interpersonal/humanistic/existential* (Vol. 3, pp. 255-279). New York: Wiley.
- Brazier, D. J. (Ed.). (1993). *Beyond Carl Rogers*. London: Constable.
- Brenner, D. (1982). *The effective psychotherapist*. Elmsford, NY: Pergamon.
- Briggs, C. (2000). Interview. *Journal of Linguistic Anthropology*, 9(1-2), 137-140.
- Brinberg, D., & McGrath, J. E. (1985). *Validity and the research process*. Newbury Park, California: Sage Publications.
- Brockmann, E., & Anthony, W. (1998). The influence of tacit knowledge and collective mind on strategic planning. *Journal of Managerial Issues*, Pittsburg.
- Brodley, B. T. (1990). Client-centred and experiential: Two different therapies. In G. Lietaer, J. Rombauts & R. V. Balen (Eds.), *Client-centred and experiential therapy in the nineties* (pp. 87-107). Leuven: Leuven University Press.
- Brown, H.I. (1988). *Rationality*. New York: Routledge.

- Brown, J. S., & Corne, L. (2004). Counselling psychology in Australia. *Counselling Psychology Quarterly*, 17(3), 287-299.
- Brown, J. S., & Duguid, P. (1998). Organizing knowledge. *California Management Review* 40, 90-111.
- Brown, L. S. (2000). Feminist therapy. In C. R. Snyder & R. E. Ingram (Eds.), *Handbook of psychological change* (pp. 358-380). New York: Wiley.
- Bruner, E. M. (1986). Ethnography as narrative. In V.W. Turner & E. M. Bruner (Eds.), *The anthropology of experience*. Chicago: University of Illinois Press.
- Buber, M. (1937). *I and thou*. New York: Scribners.
- Buber, M. (1958). *Paths in Utopia*. Boston: Beacon Press.
- Buber, M. (1967). *The knowledge of man* (M. Friedman, Trans.). New York: Harper and Pew.
- Buber, M. (1970). *I and thou* (Walter Kaufman, Trans.). New York: Touchstone Charles Scribner's Sons.
- Buber, M. (1985). *Between man and man*. London: Collier Books.
- Bugental, J. F. T. (1976). *The search for existential identity*. San Francisco: Jossey-Bass.
- Bugental, J. F. T. (1987). *The art of the psychotherapist*. New York: W.W. Norton & Company.
- Bugental, J. F. T. (1992). The betrayal of the human: Psychotherapy's mission to reclaim our lost identity In J. K. Zeig (Ed.), *The evolution of psychotherapy: The second conference* (pp. 155-164). New York: Brunner/Mazel.
- Bugental, J. F. T. (1999). Psychotherapy isn't what you think: Bringing the psychotherapeutic engagement into the living moment. New York: Zeig, Tucker & Theisen.
- Bugental, J. F. T., & Sapienza, B. G. (1992). The three R's for humanistic psychology: Remembering, reconciling and reuniting. *The Humanist Psychology*, 20, 273-284.

- Burgess, R. (Ed.). (1984). *Field research: A sourcebook and manual*. London: Allen Unwin.
- Burgess-Limerick, T., & Burgess-Limerick, R. (1998). Conversational interviews and multiple-case research in psychology *Australian Journal of Psychology*, 50, 63-70.
- Burr, V. (1995). An introduction to social constructionism. London: Routledge.
- Buss, A. R. (1975). The emerging field of the sociology of psychological knowledge. *American Psychologist*, 30, 988-1002.
- Butler, S. F., & Strupp, H. H. (1986). Specific and nonspecific factors in psychotherapy: A problematic paradigm for psychotherapy research. *Psychotherapy*, 23, 30-40.
- Campbell, H. (2008). Therapeutic process and outcome: The interplay of research. *Australian Journal of Guidance & Counselling*, 18(1), 47-52.
- Campbell, J. J. (1949). *The hero with a thousand faces*. New York: Pantheon Press.
- Cantor, N. (2003). Constructive cognition, personal goals, and the social embedding of personality. In L. G. Aspinwall & U. M. Staudinger (Eds.), *A psychology of human strengths* (pp. 49-60). Washington, DC: American Psychological Association.
- Carey, K. B., Leontieva, L., Dimmock, J., Maisto, S. A., & Batki, S. L. (2007). Adapting motivational interventions for co-morbid schizophrenia and alcohol use disorders. *Clinical Psychology Science and Practice*, 14(1), 39-57.
- Carey, T. A., Carey, M., Stalker, K., Mullan, R. J., Murray, L., & Spratt, M. (2007). Psychological change from the inside looking out: A qualitative investigation. *Counselling and Psychotherapy Research*, 7(3), 178-85.
- Carkhuff, R. R. (1969). *Helping in human relations* (Vol. 1 and 2). New York: Holt, Rineheart and Winston.

- Carpy, D. V. (1989). Tolerating the countertransference: A mutative process. *International Journal of Psycho-Analysis*, 70, 287-294.
- Carroll, L. (1920). *Alice's adventures in Wonderland*. London: The Macmillan Company.
- Carson, D. K., & Becker, K. W. (2004). When lightning strikes: Reexamining creativity in psychotherapy. *Journal of Counseling & Development*, 82(1), 111-115.
- Cartwright, D. (1998). The reversal of pathological projective identifications: The problem of patient receptivity. *British Journal of Psychotherapy* 15(1), 3-17.
- Casement, P. (1992). *Learning from the patient*. New York: Guilford Publications.
- Casonato, R., & Harris, K. (1999). "Can an enterprise really capture "tacit knowledge"? We answer two top questions on knowledge management from the Electronic Workplace 1999 Conference", *Gartner Group Research Note Select Q & A 16th March*.
- Castelnuovo, G., Faccio, E., Molinari, E., Nardone, G., & Salvini, A. (2004). A critical review of Empirically Supported Treatments (ESTS) and common factors perspective in psychotherapy. *Brief Strategic and Systemic Therapy European Review*, 1, 208-224.
- Castonguay, L. G., & Beutler, L. E. (Eds.). (2005). *Principles of therapeutic change that work*. Oxford, U.K.: Oxford University Press.
- Castonguay, L. G., Goldfried, M. R., Wiser, S. L., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology* 64, 497-504.
- Castonguay, L. G., & Hill, C. E. (Eds.). (2006). *Insight in psychotherapy*. Washington, DC: American Psychological Association Press.
- Chambers, D. E., Wedel, K. R., & Rodwell, M. K. (1992). *Evaluating social programs*. Boston: Allyn and Bacon.

- Chambless, D. L. (2002). Beware the dodo bird: The dangers of overgeneralization. *Journal of Clinical Psychology, 9*(1), 13-16.
- Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*(1), 7-18.
- Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509-535). Thousand Oaks, CA: Sage.
- Charmaz, K. (2003). Qualitative interviewing and grounded theory analysis. In J. F. Gubrium & J. A. Holstein (Eds.), *Inside interviewing: New lenses, new concerns* (pp. 311-329). Thousand Oaks, CA: Sage Publications.
- Charmaz, K. (2004). Premises, principles, and practices in qualitative research: Revisiting the foundations. *Qualitative Health Research, 14*(7), 976-993.
- Charmaz, K. (2006). Constructing grounded theory: A practical guide through qualitative analysis. London: Sage Publications.
- Charmaz, K. (2008). Grounded theory as an emergent method. In S. N. Hesse-Biber & P. Leavy (Eds.), *Handbook of emergent methods* (pp. 155-170). New York: The Guilford Press.
- Charmaz, K. (2009). Constructivist grounded theory methods. In J. M. Morse (Ed.), *Developing grounded theory: The second generation*. Walnut Creek, California: Left Coast Press.
- Charmaz, K., & Mitchell, R. (1996). The myth of silent authorship: Self, substance, and style in ethnographic writing. *Symbolic Interaction, 19*(4), 285-302.
- Chi, M. T., Glaser, R., & Farr, M. J. (Eds.). (1988). *The nature of expertise*. Hillsdale, NJ: Erlbaum.
- Chrzanowski, G. (1977). Participant observation. *Contemporary Psychoanalysis, 13*, 351-354.

- Chu, J. A. (1992). Empathic confrontation in the treatment of childhood abuse survivors, including a tribute to the legacy of Dr. David Caul. *Dissociation*, 5(2), 098-103.
- Chu, W. C., & Tsui , M. S. (2008). The nature of practice wisdom in social work revisited. *International Social Work*, 51(1), 47-54.
- Cissna, K. N., & Anderson, R. (2002). Moments of meeting: Buber, Rogers, and the potential for public dialogue. New York: Suny Press.
- Clark, A. J. (2007). *Empathy in counseling and psychotherapy: Perspectives and practices*. Mahwah, New Jersey: Lawrence Erlbaum & Associates.
- Clark, A. J. (2010). Empathy: An integral model in the counseling process. *Journal of Counseling & Development* 88(3), 346-356.
- Clark, M. M. (1986). Personal therapy: A review of empirical research. *Professional Psychology: Research and Practice*, 17(6), 541-543.
- Clark, R. A., Harden, S. L., & Johnson, W. B. (2000). Mentor relationships in clinical psychology doctoral training: Results of a national survey. *Teaching of Psychology*, 27, 262-268.
- Clarke, A. (Ed.). (2008). From grounded theory to situational analysis: What's new? Why? How? Walnut Creek, CA: Left Coast Press.
- Clarke, H., Rees, A., & Hardy, G. E. (2004). The big idea: Clients views of cognitive therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 51, 81-92.
- Clarkson, P. (1997). Variations on I and thou. *Gestalt Review*, 1, 56-70.
- Clarkson, P. (1998). Counselling psychology: Integrating theory, research, and supervised practice. New York: Routledge.
- Coan, R. W. (1989). Alternative views on the evolution of consciousness *Journal of Humanistic Psychology*, 29(2), 167-199.
- Cohen, J. (1985). Therapy through the looking glass. *Psychology: A Journal of Human Behavior* 22(2), 11-18.
- Coltart, N. E. (1988). The assessment of psychological mindedness in the diagnostic interview. *British Journal of Psychiatry*, 153, 819-820.

- Comstock, C.M. (1991). Countertransference and the suicidal MPD patient. *Dissociation*, 4(1), 25-35.
- Cooper, M. (2004). Towards a relationally-orientated approach to therapy: Empirical support and analysis. *British Journal of Guidance and Counselling*, 32(4), 451-460.
- Cooper, M. (2005). Therapists' experiences of relational depth: A qualitative interview study. *Counselling and Psychotherapy Research* 5(2), 87-95.
- Cooper, M. (2008). Essential research findings in counselling and psychotherapy: The facts are friendly. London: Sage Publications.
- Cooper, M., & McLeod, J. (2007). A pluralistic framework for counselling and psychotherapy: Implications for research. *Counselling and Psychotherapy Research*, 7(3), 135-143.
- Corsini, R. J. (Ed.). (1999). *The dictionary of psychology*. Philadelphia: Brunner-Mazel.
- Corwin, H. A. (1973). Therapeutic confrontation from routine to heroic. In G. Adler & P. G. Myerson (Eds.), *Confrontation in psychotherapy*. New York: Science House.
- Crabtree, B. F., & Miller, W. L. (1999). *Doing qualitative research*. Thousand Oaks, California: Sage.
- Craig, G. (1997). *The EFT manual*. Santa Rosa, California: Energy Psychology Press.
- Craighead, W. E., Sheets, E. S., Bjornsson, A. S., & Arnarson, E. O. (2005). Specificity and non-specificity in psychotherapy. *Clinical Psychology: Science and Practice*, 12(2), 189-193.
- Cramer, D. (1992). Personality and psychotherapy: Theory, practice, and research. Milton Keynes: Open University Press.
- Crawford, C. (2000). *Happiness is everything*. New York: Infinity Press.
- Creswell, J. (1998). Qualitative inquiry and research design: Choosing among five traditions. Thousand Oaks CA: Sage.

- Creswell, J. (2005). Educational research: Planning, conducting and evaluating quantitative and qualitative research (2nd ed.). New Jersey: Pearson Merrill Prentice Hall.
- Cronbach, L. (1975). Beyond the two disciplines of scientific psychology. *American Psychologist*, 30, 116-127.
- Crotty, M. (1998). The foundations of social research: Meaning and perspective in the research process. Thousand Oaks: Sage Publications.
- Crowley, R. M. (1977). A unique contribution *Contemporary Psychoanalysis*, 13, 412-415.
- Cuijpers, P. (1998). Minimizing interventions in the treatment and prevention of depression: Taking the consequences of the dodo bird verdict. *Journal of Abnormal Psychology Mental Health*, 7(4), 355-365.
- Cuijpers, P., van Straten, A., Andersson, G., & van Oppen, P. (2008). Psychotherapy for depression in adults: A meta-analysis of comparative outcome studies. *Journal of Consulting and Clinical Psychology*, 76(6), 909-922.
- Cummings, A. L., Hallberg, E. T., Martin, J., Slemon, A., & Hiebert, B. (1990). Implications of counselor conceptualizations for counselor education. *Counselor Education and Supervision*, 30, 120-134.
- Cunningham, D. J. (1998). Cognition as semiosis. The role of inference. *Theory and Psychology*, 8, 827-840.
- Curley, M. A. (1997). Mutuality - an expression of nursing presence. *Journal of Pediatric Nursing*, 12(4), 208-213.
- Cushman, P. (1990). Why the self is empty: Toward a historically situated psychology. *American Psychologist*, 45(5), 599-611.
- Dampney, C., Busch, P., & Richards, D. (2002). The meaning of tacit knowledge. *Australian Journal of Information Systems*, 3-13.

- Daniel, T., & McLeod, J. (2006). Weighing up the evidence: A qualitative analysis of how person-centred counsellors evaluate the effectiveness of their practice. *Counselling and Psychotherapy Research, 6*, 244-249.
- Danziger, K. (1990). Constructing the subject: Historical origins of psychological research. Cambridge: Cambridge University Press.
- David, M., & Sutton, C. D. (2004). *Social research the basics*. London: Sage Publications.
- Davidson, L. (2006). Supervision and mentorship: The use of the real in teaching. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 34*, 189-195.
- Davidson, W. S. (1989). Substantive theorizing: Another trip to the mountain. *American Journal of Community Psychology, 17*(5), 531-547.
- Davies, M. K. (2001). Knowledge (explicit and implicit): Philosophical aspects. In N. J. Smelser & P. B. Baltes (Eds.), *International encyclopedia of social and behavioural sciences* (Vol. 12, pp. 8126-8132). Amsterdam: Elsevier Science Ltd.
- Davis, K. (1986). The process of problem reformulation in psychotherapy. *Sociology of Health and Illness 8*, 44-74.
- Davis, W. H. (1972). *Peirce's epistemology*. The Hague: Martinus Nijhoff.
- Dawes, R. M. (1994). House of cards: Psychology and psychotherapy built on myth. New York: Free Press.
- de Certeau, (1984). *The practice of every day life*. Translation by Arts de Faire, London: University of California Press.
- Denker, P. G. (1946). Results of treatment of psycho-neuroses by the general practitioner. A follow-up study of 500 cases. New York. *State Journal of Medicine, 46*, 2164-2166.
- Denzin, N. (1983). Interpretive interactionism. In G. Morgan (Ed.), *Beyond method: Strategies for social research* (pp. 129-146). Beverly Hills CA: Sage.

- Denzin, N. K. (1978). *The research act: A theoretical introduction to sociological methods* (2nd ed.). New York: McGraw-Hill.
- Denzin, N. K. (1986). Behaviorism and beyond. *Contemporary Sociology*, 15, 553 - 556.
- Denzin, N. K. (2001). *Interpretive interactionism (Applied social research methods)* (2nd ed.). New York: Sage Publications.
- Denzin, N. K., & Lincoln, Y. S. (Eds.). (1994). *Handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Denzin, N. K., & Lincoln, Y. S. (Eds.). (2005). *The Sage handbook of qualitative research*. New York: Sage Publications.
- DeRoos, Y. S. (1990). The development of practice wisdom through human problem-solving processes. *Social Service Review*, 64, 276-287.
- Derrida, J. (1976). *Of grammatology*. (J. C. Spivak, Trans.). Baltimore: John Hopkins University Press.
- DeRubeis, R. J., Brotman, M. A., & Gibbons, C. J. (2005). A conceptual and methodological analysis of the nonspecifics argument. *Clinical Psychology: Science and Practice*, 12, 174-183.
- DeRubeis, R. J., & Feeley, M. (1990). Determinants of change in cognitive therapy for depression. *Cognitive Therapy and Research*, 14, 469-482.
- Dewey, J. (1922). *Human nature and conduct*. New York: Henry Holt & Co.
- Dewey, J. (1944). *Democracy and education*. New York: Free Press.
- Dewey, J. D. (1933). *How we think, a restatement of the relation of reflective thinking to the educative process*. Boston: D.C. Heath.
- Diamond, M. A. (2007). Organizational change and the analytic third: Locating and attending to unconscious organizational psychodynamics. *Psychoanalysis, Culture & Society* 12, 142-164.
- Dickens, C. (1859). *A tale of two cities*. London: Penguin.
- Dillard, A. (1982). *Living by fiction*. New York: Harper & Row.

- Dilthey, W. (1894). *Descriptive psychology and historical understanding* (R. Zaner & K. Heigen, Trans.). The Hague: Martinus Nijhoff (Original work published in 1894).
- Dokecki, P. R. (1992). The tragic-comic professional: Basic considerations for ethical reflective-generative practice. Pittsburgh, Pennsylvania: Duquesne University Press.
- Dollinger, S. J., Reader, M. J., Marnett, J. P., & Tylanda, B. (1983). Psychological-mindedness, psychological construing, and the judgment of deception. *The Journal of General Psychology*, 108, 183-191.
- Dollinger, S. J., & Riger, A. L. (1984). On penetrating the "mask": The role of sagacity and acumen in a word-association clinical judgment task. *Journal of Personality and Social Psychology*, 46, 145-152.
- Donmoyer, R. (1990). Generalizability and the single-case study. In E. W. Eisner & A. Peshkin (Eds.), *Qualitative inquiry in education: The continuing debate* (pp. 175-200). New York: Teachers College Press.
- Dosamantes-Beaudry, I. (2007). Somatic transference and countertransference in psychoanalytic intersubjective dance/movement therapy *American Journal of Dance Therapy*, 29, 73-89.
- Doss, B. D. (2004). Changing the way we study change in psychotherapy. *Clinical Psychology: Science and Practice*, 11(4), 368-386.
- Downing, J. (2004). Psychotherapy practice in a pluralistic world: Philosophical and moral dilemmas. *Journal of Psychotherapy Integration*, 14(2), 123-148.
- Dreyfus, H. L., & Dreyfus, S. E. (1986). *Mind over machine: The power of human intuition and expertise in the era of the computer*. New York: Free Press.
- Dryden, W. (Ed.). (2002). *Handbook of individual therapy*. London: Sage.
- Du Bois, B. (1983). Passionate scholarship: Notes on values, knowing and method in feminist social science. In G. Bowles, R. Duelli-Klein & R.

- Klein (Eds.), *Theories of women's studies* (pp. 105-116). London: Routledge.
- Dublin, J. E. (1971). A further motive for psychotherapists: communicative intimacy. *Psychiatry*, 34(4), 401-409.
- Dummett, M. (1991). *The logical basis of metaphysics*. London: Duckworth.
- Duncan, B. L. (2002). The legacy of Saul Rosenzweig: The profundity of the Dodo Bird. *Journal of Psychotherapy Integration*, 12(1), 32-57.
- Duncan, B., & Miller, J. B. (2000). The client's theory of change: Consulting the client in the integrative process. *Journal of Psychotherapy Integration*, 10(2), 169-187.
- Duncan, B., Miller, S., & Sparks, J. (2004). The myth of the medical model. In B. Duncan, S. Miller & J. Sparks (Eds.), *The heroic client: A revolutionary way to improve effectiveness through client-directed outcome-informed therapy* (pp. 21-48). San Francisco, CA: John Wiley & Sons.
- Duncan, B., Solovey, A., & Rusk, G. (1992). *Changing the rules: A client-directed approach to therapy*. New York: Guilford.
- Duncan, B. L., Hubble, M. A., & Miller, S. D. (1997). *Psychotherapy with Impossible cases: The efficient treatment of therapy veterans*. New York: Norton.
- Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (Eds.). (2010). *The heart and soul of change: Delivering what works in therapy* (2 ed.). Washington, D.C: American Psychological Association.
- Dunne, J. (1993). *Back to the rough ground: Phronesis and techne in modern philosophy and in Aristotle*. Indiana: University of Notre Dame Press.
- Dybicz, P. (2004). An inquiry into practice wisdom. *Families in Society*, 85(2), 197-203.
- Eaton, J. (1998). Gadamer: Psychotherapy as conversation. *European Journal of Psychotherapy, Counselling and health*, 1(3), 421-434.

- Ecker, B., & Hulley, L. (1996). Depth oriented brief therapy: How to be brief when you were trained to be deep, and vice versa. San Francisco: Jossey-Bass.
- Eco, U. (1983). Horns hooves insteps. In U. Eco & T. A. Sebeok (Eds.), *The sign of three* (pp. 199-219). Bloomington Indiana: Indiana University Press.
- Eells, T. D. (1999). What do we know about master therapists? *Journal of Psychotherapy Practice Research*, 8, 414-417.
- Egan, G. (1982). The skilled helper: A model for systematic helping and interpersonal relating (2nd ed.). Monterey, CA: Brooks/Cole.
- Egan, K. (1998). The skilled helper. A problem-management approach to helping (6th ed.). Pacific Grove: Brooks/Cole.
- Egan, G. (2007). *The skilled helper* (8th ed.). Pacific Grove, CA: Thomson-Brooks & Cole.
- Ehrenberg, D. B. (1992). The intimate edge: Extending the reach of psychoanalytic interaction. New York: W. W. Norton.
- Ehrenberg, D. B. (1996). On the analyst's emotional availability and vulnerability. *Contemporary Psychoanalysis*, 32(2), 275-286.
- Eisenhardt, K. (2002). Building theories from case study research. In A. M. Huberman & M. Miles (Eds.), *The qualitative researcher's companion* (pp. 5-36). Thousand Oaks CA: Sage.
- Elliott, R., Shapiro, D.A., Firth-Cozens, J., Stiles, W.B., Hardy, G.E., Llewelyn, S.P., & Margison, F.R. (1994). Comprehensive Process Analysis of insight events in cognitive-behavioural and psychodynamic-interpersonal psychotherapies. *Journal of Counselling Psychology*, 41, 449-463.
- Eliot, T.S. (1934). *Collected poems* (1909-1962): *Choruses from the rock* (p.161) London: Faber.
- Elkin, I. (1994). The NIMH Treatment of Depression Collaborative Research Program: Where we began and where we are In A. E. Bergin & S. L.

- Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 114-139). Oxford: John Wiley & Sons.
- Elkin, I., Shea, T., Watkins, J., Imber, S., Sotsky, S., Collins, J., et al. (1989). National Institute of Mental Health treatment of depression collaborative research program: General effectiveness of treatments *Archives of General Psychiatry*, 46, 971-982.
- Elkins, D. N. (2007). The medical model in psychotherapy: Its limitations and failures. *Journal of Humanistic Psychology*, 49(66), 66-84.
- Elliot, R., Watson, J. C., Greenberg, L., Goldman, R., & Davis, K. (2001). Learning process experiential therapy: An introduction to emotionally focused therapy. Unpublished Manuscript.
- Elliott, R. (1979). How clients perceive helper behaviours. *Journal of Counseling Psychology*, 26, 285-294.
- Elliott, R. (1983). Fitting process research to the practicing psychotherapist. *Psychotherapy: Theory: Research, and Practice*, 20, 47-55.
- Elliott, R. (1984). A discovery-oriented approach to significant change events in psychotherapy: Interpersonal Process Recall and Comprehensive Process Analysis. In L. N. Rice & L. S. Greenberg (Eds.), *Patterns of Change*. New York: The Guildford Press.
- Elliott, R. (1985). Helpful and non-helpful events in brief counseling interviews: An empirical taxonomy. *Journal of Counseling Psychology*, 32, 307-322.
- Elliott, R. (1986). Interpersonal Process Recall (IPR) as a psychotherapy process research method. In L. Greenberg & W. Pinsof (Eds.), *The psychotherapeutic process* (pp. 503-527). New York: Guilford.
- Elliott, R. (1989). Comprehensive process analysis: Understanding the change process in significant therapy events. In M. J. Packer & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 165-184). Albany, NY, US: State University of New York Press.

- Elliott, R. (1991). Five dimensions of therapy process. *Psychotherapy Research, 1*, 92-103.
- Elliott, R., & Feldstein, L. (1978). Helping intention rating procedure. University of Toledo.
- Elliott, R., James, E., Reimschuessel, C., Cislo, D., & Sack, N. (1985). Significant events and the analysis of immediate therapeutic impacts. *Psychotherapy,, 22*, 620-630.
- Elliott, R., & Shapiro, D. (1992). Client and therapist as analysts of significant events. In S. Toukmanian & D. Rennie (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches* (pp. 163-186). Newbury Park CA: Sage.
- Elliott, R., Watson, J. C., Goldman, R. N., & Greenberg, L. S. (2004). *Learning emotion-focused therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.
- Ellyard, P. (1998). *Ideas for the new millennium*. Melbourne: Melbourne University Press.
- Eraut, M. (1995). Schön shock: A case for reframing reflection-in-action? *Teachers and Teaching: Theory and Practice, 1*(1), 9-22.
- Erikson, E. (1963). *Childhood and society* (2nd ed.). New York: Norton.
- Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1993). *Doing naturalistic inquiry. A guide to methods*. London: Sage.
- Eron, J. B., & Lund, T. W. (1996). *Narrative solutions in brief therapy*. New York: Guilford Press.
- Erskine, R. G., Moursund, J. P., & Trautmann, R. L. (1999). *Beyond empathy: A theory of contact-in-relationship*. Philadelphia: Brunner/Mazel.
- Etherington, K. (2004). *Becoming a reflexive researcher: Using our selves in research*. London: Jessica Kingsley Publishers.

- Evans, F. B. (1996). Harry Stack Sullivan: Interpersonal theory and psychotherapy. London: Routledge.
- Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting and Clinical Psychology*, 16, 319-324.
- Ezzy, D. (2002). Qualitative analysis: Practice and innovation. London: Routledge.
- Falkum, E. (2008). Phronesis and techne: The debate on evidence-based medicine in psychiatry and psychotherapy. *Philosophy Psychiatry & Psychology*, 15.
- Farber, B. A. (1985). The genesis, development, and implications of psychological-mindedness in psychotherapists. *Psychotherapy*, 22(2), 170-177.
- Farber, B. A. (2006). *Self-disclosure in psychotherapy* New York: The Guilford Press.
- Feather, N. T. (1993). Authoritarianism and attitudes towards high achievers. *Journal of Personality and Social Psychology*, 65, 152-164.
- Feather, N. T. (1998). Attitudes towards high achievers, self-esteem, and value priorities for Australian, American, and Canadian students. *Journal of Cross-Cultural Psychology*, 29, 749-759.
- Feather, N. T., & Adair, J. G. (1999). National identity, national favoritism, global self-esteem, tall poppy attitudes, and value priorities in Australian and Canadian samples. In J. C. Lasry, J. Adair & K. Dion (Eds.), *Latest contributions to cross-cultural psychology* (pp. 42-61). Lisse, Swets & Zeitlinger.
- Feller, C. P., & Cottone, R. R. (2003). The importance of empathy in the therapeutic alliance. *Journal of Humanistic Counseling, Education and Development*, 42, 53-61.
- Feltham, C., & Horton, I. (2006). *The Sage handbook of counselling and psychotherapy* (2nd ed.). Thousand Oaks, CA: Sage.

- Fenichel, O. (1930). The psychology of transvestism. *International Journal of Psycho-Analysis*, 11, 211-227.
- Ferenczi, S. (1926). Further contributions to the theory and technique of psycho-analysis. London: Karnac Books.
- Ferguson, M. (1980). The Aquarian conspiracy: Personal and social transformation in the 1980's. Los Angeles: Tarcher.
- Ferster, C. B. (1973). A functional analysis of depression. *American Psychologist*, 28, 857-870.
- Fife, W. (2005). Doing fieldwork: Ethnographic methods of research in developing countries and beyond. New York: Palgrave, Macmillan.
- Fine, M. (1994). Working the hyphens: Reinventing the Self and Other in qualitative research. In N. Denzin & Y. Lincoln. (Eds.), *Handbook of qualitative research* (pp. 70-82). Newbury Park, CA: Sage.
- Fishman, D. B. (1999). *The case for a pragmatic psychology*. New York: NYU Press.
- Fishman, D. B. (2000). Transcending the efficacy versus effectiveness research debate: Proposal for a new, electronic journal of pragmatic case studies. *Prevention & Treatment.*, 3(1), 89-106.
- Flaskas, C. (2009). The therapist's imagination of self in relation to clients: Beginning ideas on the flexibility of empathic imagination. *The Australian and New Zealand Journal of Family Therapy*, 30 (3), 147-159.
- Fix, A. J., & Haffke, E. A. (1975). Relationship between psychotherapy skills and level of training in a psychiatric residency program. *Social Science & Medicine*, 9(8&9), 489-491.
- Flay, B. R. (1985). Psychosocial approaches to smoking prevention: A review of findings. *Health Psychology*, 4, 449-488.
- Flexner, S. B. (1987). *The random house dictionary*. New York: Random House.

- Flyvbjerg, B. (2006). Making organization research matter: Power, values and phronesis. In S. R. Clegg, C. Hardy, T. B. Lawrence & W. R. Nord (Eds.), *The Sage handbook of organization studies* (pp. 370-387). Thousand Oaks, CA: Sage.
- Fonagy, P. (2001). *Attachment theory and psychoanalysis*. New York: Other Press.
- Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization and the development of the self*. New York: Other Books.
- Fonagy, P., Target, M., & Gergely, G. (2000). Attachment and borderline personality disorder: A theory and some evidence. *The Psychiatric Clinics of North America*, 23, 103-122.
- Fook, J., Ryan, M., & Hawkins, L. (2000). Professional expertise: Practice, theory and education for working with uncertainty. London: Whiting and Birch.
- Ford, D. H., & Urban, H. B. (1963). *Systems of psychotherapy*. New York: Wiley.
- Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry*, 36, 717-732.
- Foucault, M. (1972). *The archaeology of knowledge* (A. M. S. Smith, Trans.). London: Routledge.
- Fox, N. J. (1993). *Postmodernism, sociology and health*. Philadelphia Open University Press.
- Frank, A. W. (2006a). Book review: Practice and the human sciences: The case for judgment-based practices of care. *Health: An Interdisciplinary for the Social Study of Health*, 10(2), 252-255.
- Frank, J. D. (2006b). Therapeutic factors in psychotherapy. *Focus*, 4, 306-311.

- Frank, J. D. (1961). *Persuasion and healing*. Baltimore, MD: Johns Hopkins University Press.
- Frank, J. D. (1973). *Persuasion and healing: A comparative study of psychotherapy* (2nd ed.). Baltimore, MD: John Hopkins University Press.
- Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University.
- Frank, J. B., Gliedman, L. H., Imber, S. D., Stone, A. R., & Nash, E. H. (1959). Patients' expectancies and relearning as factors determining improvement in psychotherapy. *American Journal of Psychiatry*, 115, 961-968.
- Frankel, Z. F., & Levitt, H. M. (2008). Clients' experiences of disengaged moments in psychotherapy: A grounded theory analysis. *Journal of Contemporary Psychotherapy*, 39, 171-186.
- Frankl, V. E. (1984). *The unheard cry for meaning: Psychotherapy and humanism*. New York: Washington Square Press.
- Fraser, J. S., & Solovey, A. D. (2006). *Second order change in psychotherapy: The golden thread that unites effective treatments*. Washington, D.C: American Psychological Association Books.
- Freedman, N. (1983). On psychoanalytic listening: The construction, paralysis, and reconstruction of meaning. *Psychoanalytic Contemporary Thought*, 6, 405-434.
- Freshwater, D., & Rolfe, G. (2001). Critical reflexivity: A politically and ethically engaged research method for nursing. *Journal of Research in Nursing*, 6(1), 526-537.
- Freud, S. (1915). Instincts and their vicissitudes. In J. Strachey (Ed.), *Standard edition of the complete psychological works of Sigmund Freud* (pp. 111-140). London: Hogarth Press.

- Freud, S. (1912). *Recommendations to physicians practicing psychoanalysis* (2001 ed. Vol. 12 ed.). London: Vintage.
- Frey, D. H. (1975). The anatomy of an idea: Creativity in counseling. *Personnel and Guidance Journal*, 54, 23-27.
- Friedman, M. (1985). *The healing dialogue in psychotherapy*. New York: Jason Aronson, Inc.
- Fromm-Reichmann, F. (1950). *Principles of intensive psychotherapy*. Chicago, IL: University of Chicago Press.
- Gabbay, M. B., Kiemle, G., & Maguire, C. (1999). Clinical supervision for clinical psychologists: Existing provision and unmet needs. *Clinical Psychology and Psychotherapy*, 6, 404-412.
- Gadamer, H. G. (1975). *Truth and method*. London: Sheed and Ward.
- Gallagher, M. S., & Hargie, O. D. W. (1992). The relationship between counsellor interpersonal skills and the core conditions of client-centred counselling. *Counselling Psychology Quarterly*, 5(1), 3-16.
- Gans, J. S., & Weber, R. L. (2003). The detection of shame in group psychotherapy: Uncovering the human emotion. In J. S. Gans (Ed.), *Difficult topics in group psychotherapy* (pp. 1-20). London: Karnac books.
- Gardner, H. (1983). *Frames of mind: the theory of multiple intelligences*. New York: Basis Books.
- Garfield, S. (1997). The therapist as a neglected variable in psychotherapy research. *Clinical Psychology: Science and Practice* 4,(1), 40-43.
- Garfield, S. L. (1976). Research on client variables in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 191-232). New York: John Wiley and Son.
- Garfield, S. L. (1990). Issues and methods in psychotherapy process research. *Journal of Consulting and Clinical Psychology*, 58, 273-280.

- Garfield, S. L. (1992). Eclectic psychotherapy: A common factors approach. In M. R. Goldfried & J. C. Norcross (Eds.), *Handbook of psychotherapy integration* (pp. 169-201). New York Basic Books.
- Garfield, S. L. (1995). *Psychotherapy: An eclectic-integrative approach* (2nd ed.). New York: Wiley Press.
- Garfield, S. L. (1996). Some problems associated with "validated" forms of psychotherapy. *Clinical Psychology: Science and Practice*, 3, 218-229.
- Gassner, S., Sampson, H., Weiss, J., & Brumer, S. (1982). The emergence of warded-off contents. *Psychoanalysis and Contemporary Thought*, 5(1), 55-75.
- Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy*, 27, 143-153.
- Gaston, L., & Marmar, C. (1994). The California psychotherapy alliance scales. In A. O. Horvath & L.S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 85-108). New York: John Wiley & Sons.
- Geertz, C. (1973). Thick description: Toward an interpretative theory of culture *The interpretation of cultures*. New York: Basic Books.
- Geertz, C. (1988). *Work and lives: The anthropologist as author*. Stanford, California: Stanford University Press.
- Geller, J., Cooley, A., & Hartley, D. (1981). Images of the psychotherapist: A theoretical and methodological perspective. *Imagination, Cognition and Personality*, 1, 123-146.
- Geller, J., & Farber, B. A. (1993). Factors influencing the process of internalization in psychotherapy. *Psychotherapy Research*, 3, 166-180.
- Geller, J. D. (2005). Style and its contribution to a patient-specific model of therapeutic technique. *Psychotherapy: Theory, Research, Practice, Training*, 42 (4), 469-482.

- Geller, J. D., Norcross, J. C., & Orlinsky, D. E. (2005). Boundaries and internalization in the psychotherapy of psychotherapists: Clinical and research perspectives. In J. D. Geller (Ed.), *The psychotherapist's own psychotherapy* (pp. 379-404). New York: Oxford University Press.
- Geller, S., & Greenberg, L. (2002). Therapeutic presence: Therapists experience of presence in the psychotherapy encounter in psychotherapy. *Person Centered & Experiential Psychotherapies*, 1, 71-86.
- Gelso, C. J. 2010. Countertransference. *Corsini Encyclopedia of Psychology*. 1-3.
- Gelso, C., Hayes, J. A., & Diemer, R. A. (1991). Countertransference and the reputedly excellent therapist. *Psychotherapy: Theory, Research, Practice, Training*, 28(3), 411-421.
- Gelso, C. J., & Carter, J. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *Counseling Psychologist*, 13(155-243).
- Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology* 41, 296-306.
- Gelso, C. J. & Hayes, J. A. (1998). *The psychotherapy relationship*. New York: Wiley.
- Gelso, C. J., & Hayes, J. A. (2001). Countertransference management. *Psychotherapy (Chicago, Ill.)*, 38(4), 418-422.
- Gelso, C. J., Hill, C. E., & Kivlighan, D. M. J. (1991). Transference, insight and the therapist's intentions during a psychotherapeutic hour. *Journal of Counseling and Development*, 69, 428-433.
- Gelso, C. J., Hill, C. E., Mohr, J. J., Rochlen, A. B., & Zack, J. (1999). Describing the face of transference: Psychodynamic therapists' recollections about transference in cases of successful long-term therapy. *Journal of Counseling Psychology*, 46, 257-267.

- Gendlin, E. T. (1964). A theory of personality change. In P. Worchel & D. Byrne (Eds.), *Personality change* (pp. 100-148). New York: John Wiley & Sons.
- Gendlin, E. T. (1968). The experiential response. In E. Hammer (Ed.), *Use of interpretation in treatment*. New York: Grune & Stratton.
- Gendlin, E. T. (1969). Focusing. *Psychotherapy: Theory, Research, and Practice*, 6, 4-15.
- Gendlin, E. T. (1996). Focusing-oriented psychotherapy. A manual of the experiential method. New York: Guilford.
- Gendlin, E. T., Beebe, J., Cassens, J., Klein, M., & Oberlander, M. (1968). Focusing ability in psychotherapy, personality, and creativity. In J. M. Shlien (Ed.), *Research in psychotherapy. Vol. III* (pp. 217-241). Washington, DC: APA.
- Gergen, K. (1994). Exploring the postmodern: Perils or potentials? *American Psychologist*, 49(5), 412-416.
- Gergen, K. (1997). *Realities and relationships: Soundings in social construction*. Cambridge, Massachusetts: Harvard University Press.
- Gergen, K., & Davis, K. (Eds.). (1985). *The social construction of the person*. New York: Springer Verlag.
- Gergen, K., & Gergen, M. M. (1991). Toward reflexive methodologies. In E. Steier (Ed.), *Research and reflexivity*. Newberry Park, London: Sage.
- Gergen, K. J. (2001). *Social constructionism in context* (2nd ed.). London: Sage.
- Gerrard, J. (1994). Spaces in between. *British Journal of Psychotherapy*, 10(4), 557-567.
- Gibbs, J., R. W. (1997a). How language reflects the embodied nature of creative cognition. In T. B. Ward, S. M. Smith & J. Vaid (Eds.), *Creative thought: An investigation of conceptual structures and*

- processes* (pp. 351-374). Washington, DC: American Psychological Association.
- Gibbs, J., R. W. (Ed.). (1997b). *Creative thought: An investigation of conceptual structures and processes*. Washington, DC: American Psychological Association.
- Gifford, E. V., & Hayes, S. C. (1999). Functional contextualism: A pragmatic philosophy for behavioral science. In W. O'Donohue & R. Kitchener (Eds.), *Handbook of behaviorism* (pp. 285-327). San Diego: Academic Press.
- Gilbert, P. (Ed.). (2005). *Compassion: Conceptualisations, research and use in psychotherapy* New York: Routledge.
- Gill, J. H. (2000). *The tacit mode: Michael Polanyi's postmodern philosophy*. Albany, New York: State University of New York Press.
- Gill, M. M. (1982). Analysis of transference: Volume 1 theory and technique. *Psychological Issues*, (Monograph 53).
- Gillett, E. (1998). Relativism and the social-constructivist paradigm. *Philosophy, Psychiatry, & Psychology*, 5(1), 37-48.
- Gillett, G. (1995). The philosophical foundations of qualitative psychology. *The Psychologist*, 8(111-114).
- Gilroy, P. (1993). Reflections on Schön: An epistemological critique and a practical alternative. *Journal of Education for Teaching*, 19(2), 125-143.
- Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Mill Valley, CA: Sociology Press.
- Glass, G. V. (1976). Primary, secondary and meta-analysis research. *Educational Researcher*, 5, 3-8.

- Glesne, C. (1999). *Becoming qualitative researchers: An introduction* (2nd ed.). Don Mills, Ontario Canada: Longman.
- Goetz, J., & LeCompte, M. (1984). *Ethnography and qualitative design in educational research*. Orlando, Florida: Academic Press.
- Gold, J. R. (1994). When the patient does the integrating: Lessons for theory and practice. *Journal of Psychotherapy Integration*, 4, 133-158
- Goldberg, A. (Ed.). (1980). *Advances in self-psychology*. New York: International Universities Press.
- Goldberg, A. (Ed.). (1991). *The evolution of self psychology*. Hillsdale NJ: The Analytic Press.
- Goldfried, M. (2000). Consensus in psychotherapy research and practice: Where have all the findings gone? *Psychotherapy Research*, 10(1), 1-16.
- Goldfried, M. R., & Norcross, J. C. (Eds.). (2003). *Handbook of psychotherapy integration* New York: Guilford Press.
- Goldfried, M. R., & Wolfe, B. E. (1996). Psychotherapy practice and research: Repairing a strained alliance. *The American Psychologist*, 51, 1007-1016.
- Goldfried, M. R., & Wolfe, B. E. (1998). Toward a more clinically valid approach to therapy research. *Journal of Consulting and Clinical Psychology*, 66(1), 143-150.
- Goldman, D. (1993). In search of the real: The origins and originality of D. W. Winnicott. Northvale, NJ: Jason Aronson.
- Goldman, L. (1976). A revolution in counseling research. *Journal of Counseling Psychology* 23(6), 543-552.
- Goleman, D. P. (1995). *Emotional intelligence: Why it can matter more than IQ for character, health and lifelong achievement*. . New York: Bantam Books.

- Gomez-Schwartz, B. (1978). Effective ingredients in psychotherapy: Prediction of outcome variables. *Journal of Consulting and Clinical Psychology, 46*, 1023-1035.
- Goodson, M. R. (1977). *Humanistic Considerations in Graduate Education and Research*. Paper presented at the Annual Meeting of the American Educational Research Association.
- Goolishian, H. (1990). Family therapy: An evolving story. *Contemporary Family Therapy, 12*(3), 173-180.
- Goolishian, H., & Anderson, H. (1987). Language systems and therapy: An evolving idea. *Psychotherapy, 24*, 529-538.
- Goolishian, H. A. (1990). Therapy as a linguistic system: Hermeneutics, narrative and meaning. *The Family Psychologist, 6*, 14-45.
- Gordon, N. S. (2000). Researching psychotherapy, the importance of the client's view: A methodological challenge *The Qualitative Report, 4*(3 & 4).
- Gore, C., & Gore, E. (1999). Knowledge management: The way forward *Total Quality Management, 10*(4/5), 554-560.
- Gotthold, J., & Sorter, D. (2006). Moments of meeting: An exploration of the implicit dimensions of empathic immersion in adult and child treatment *International Journal of Psychoanalytic Self Psychology, 1*(1), 103-119.
- Grafanaki, S. (2001). What counseling research has taught us about the concept of congruence: Main discoveries and unresolved issues. In G. Wyatt (Ed.), *Rogers' therapeutic conditions: Evolution, theory and practice Volume 1: Congruence* (pp. 18-35). Ross-on-Wye: PCCS Books.
- Grafanaki, S., & McLeod, J. (2002). Refinement and expansion of the concept of experiential congruence: A qualitative analysis of client and counsellor narrative accounts of significant events in time-limited person-centred therapy *Counselling and Psychotherapy Research, 2*(1), 20-33.

- Graff, H., & Luborsky, L. (1977). Long-term trends in transference and resistance: A quantitative analytic method applied to four psychoanalyses. *Journal of American Psychoanalytic Association*, 25, 471-490.
- Grant, A. M. (2001). Rethinking psychological mindedness: Metacognition, self-reflection, and insight *Behaviour Change*, 18(1), 8-17.
- Grant, J., & Crawley, J. (2002). *Transference and projection: Mirrors to the self*. Buckingham: Open University Press.
- Grant, J. A., & Schofield, M. (2007). Career-long supervision: Realities and controversies. [Special issue on supervision]. *Counselling and Psychotherapy Research*, 7(1), 3-11.
- Greenacre, P. (1954). The role of transference: Practical considerations in relation to psychoanalytic therapy. *Journal of American Psychoanalytic Association*, 2, 671-684.
- Greenberg, J. (1991). *Oedipus and beyond: A clinical theory*. Cambridge, MA: Harvard University Press.
- Greenberg, L. (1986). Research strategy. In L. Greenberg & W. Pinsof (Eds.), *Psychotherapeutic process: A research handbook*. New York: Guilford Press.
- Greenberg, L. (1996). The power of empathic exploration: A process-experiential/Gestalt perspective on the case of Jim Brown. In B. A. Farber, D. C. Brink & P. M. Raskin (Eds.), *The psychotherapy of Carl Rogers: Cases and commentary* (pp. 251-260). New York: Guilford.
- Greenberg, L., & Geller, S. (2001). Congruence and therapeutic presence. In P. Griffiths (Ed.), *What emotions really are*. Chicago: University of Chicago Press.
- Greenberg, L., Rice, L., & Elliott, R. (1993). *Facilitating emotional change: The moment-by-moment process*. New York: Guilford Press.
- Greenberg, L. E. (1994). The investigation of change: Its measurement and explanation. In R. L. Russel (Ed.), *Reassessing psychotherapy research* (pp. 114-143). New York/London: Guilford Press.

- Greenberg, L. S. (1986). Change process research. *Journal of Consulting and Clinical Psychology, 54*, 4-9.
- Greenberg, L. S. (2002). *Emotion-focused therapy: Coaching clients to work through their feelings*. Washington, DC: American Psychological Association.
- Greenberg, L. S., & Elliott, R. (1997). Varieties of empathic responding. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 167-186). Washington, DC: American Psychological Association.
- Greenberg, L. S., & Johnson, S. M. (1988). *Emotionally focused therapy for couples*. New York: Guilford Press.
- Greenberg, L. S., & Pinsof, W. M. (Eds.). (1986). *The psychotherapeutic process: A research handbook*. New York: Guilford.
- Greenberg, R. P., Constantino, M. J., & Bruce, N. (2006). Are patient expectations still relevant for psychotherapy process and outcome? *Clinical Psychology Review, 26*, 657-812.
- Greenson, R. (1965). The working alliance and the transference neurosis. *Explorations in psychoanalysis* (pp. 199-224). New York: International University Press.
- Greenson, R. (1967). *The technique and practice of psychoanalysis*. New York: International Universities Press.
- Griffith, J. L., & Griffith, M. E. (2002). Encountering the sacred in psychotherapy: How to talk with people about their spiritual lives. New York: The Guildford Press.
- Grindlinger, J. L. (2003). Humanistic psychotherapies: Handbook of research and practice *American Journal of Psychiatry 160*, 400-401.
- Gross, M. L. (1978). The psychological society: A critical analysis of psychiatry, psychotherapy, psychoanalysis and the psychological revolution. New York: Random House.

- Guba, E. G., & Lincoln, Y. (1982). Epistemological and methodological bases of naturalistic inquiry. *Educational Communication and Technology Journal, 30*, 233-252.
- Guba, E. G., & Lincoln, Y. (1989). *Fourth generation evaluation*. Newbury Park: Sage Publications.
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). London: Sage.
- Gurman, A. (1977). The patient's perception of the therapeutic relationship. In A. Gurman & A. Razin (Eds.), *Effective psychotherapy: A handbook of research*. (pp. 503-543). New York: Pergamon Press.
- Guy, J. D. (1987). *The personal life of the psychotherapists*. New York: Wiley.
- Habermas, J. (1972). *Knowledge and human interest* (J. Shapiro, Trans.). London: Heinemann.
- Haggard, E. A., & Isaacs, K. S. (1966). Micro-momentary facial expressions as indicators of ego mechanisms in psychotherapy. In L. A. Gottschalk & A. H. Auerbach (Eds.), *Methods of research in psychotherapy* (pp. 154-165). New York: Applston Century Crofts.
- Haldin-Herrgard, T. (2000). Difficulties in diffusion of tacit knowledge in organizations. *Journal of Intellectual Capital, 1*(4), 357-367.
- Haley, J. (1976). *Problem-solving therapy*. San Francisco: Jossey Bass.
- Hall, J. (1992). Psychological-mindedness: A conceptual model. *American Journal of Psychotherapy, 66*(1), 131-140.
- Hall, W. A., & Callery, P. (2001). Enhancing the rigor of grounded theory: Incorporating reflexivity and relationality. *Qualitative Health Research, 11*, 257-272.
- Hallberg, L. R. M. (2006). The "core" category of grounded theory: Making constant comparisons. *International Journal of Qualitative Studies on Health and Well-being, 1-4*, 1748-2623.

- Hamilton, D. (1994). Traditions, preferences and postures in applied qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 60-70). London: Sage Publications.
- Hammersley, M. (2004). Teaching qualitative method: Craft, profession or bricolage? In C. Seale, G. Gobo, J. F. Gubrium & D. Silverman (Eds.), *Qualitative research practice* (pp. 549-560). London: Sage.
- Hanfling, O. E. (1981). *Essential readings in logical positivism*. Oxford: Blackwell.
- Hanna, F. J., Giordano, F., Dupuy, P., & Puhakka, K. (1995). Agency and transcendence: The experience of therapeutic change. *Humanistic Psychologist*, 23, 139-160.
- Hanna, F. J., & Ritchie, M. H. (1995). Seeking the active ingredients of psychotherapeutic change: Within and outside the context of therapy. *Professional Psychology: Research and Practice*, 26(2), 176-183.
- Hannush, M. J. (2007). An existential-dialectical-phenomenological approach to understanding cultural tilts: Implications for multicultural research and practice. *Journal of Phenomenological Psychology*, 38, 7-23.
- Hansen, J. T. (2004). Thoughts on knowing: Epistemic implications of counseling practice. *Journal of Counseling & Development* 82(2), 131-138.
- Hardiker, P., & Barker, M. (1981). *Theories of practice in social work*. London: Academic Press.
- Harding, S. (Ed.). (1987). *Feminism and methodology: Social science issues*. Bloomington, Indiana: Indiana University Press.
- Hardtke, K., & Angus, L. (2004). The narrative assessment Interview: Assessing self change in psychotherapy. In L. Angus & J. McLeod (Eds.), *Handbook of narrative and psychotherapy: Practice, theory and research* (pp. 247-262). Thousand Oaks, CA Sage.
- Harré, R. (Ed.). (1986). *The social construction of emotions*. New York: Blackwell.

- Hayes, A. M., Laurenceau, J. P., Feldham, G., Strauss, J. L., & Cardaciotto, L. (2007). Change is not always linear: The study of nonlinear and discontinuous patterns of change in psychotherapy. *Clinical Psychology Review, 27*, 715-723.
- Hayes, R., & Oppenheim, R. (1997). Constructivism: Reality is what you make it. In T. Sexton & B. Griffin (Eds.), *Constructivist thinking in counseling practice, research and training* (pp. 19-41). New York: Teachers College Press.
- Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavior therapy. *Behavior Therapy, 35*, 639-665.
- Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment Therapy: An experiential approach to behavior change*. New York: Guilford Press.
- Hayley, J. (1976) Problem-solving therapy: New strategies for effective family therapy. San Francisco: Jossey-Bass.
- Healy, C. C., & Welchert, A. J. (1990). Mentoring relations: A definition to advance research and practice. *Educational Researcher, 19*(9), 17-21.
- Hecker, L. L., & Kottler, J. A. (2002). Growing creative therapists: Introduction to special issue. *Journal of Clinical Activities, Assignments & Handouts in Psychotherapy Practice, 2*(2), 1-3.
- Heidegger, M. (1962). *Being and time*. New York: The Camelot Press.
- Heidegger, M. (1992). (1924-1925) *Platon: Sophistes*. GA 19. Frankfurt am Main: Klostermann.
- Hekman, S. J. (1990). *Gender and knowledge: Elements of a postmodern feminism*. Boston, MA: Northeastern University Press.
- Held, B. S. (1991). The process/content distinction in psychotherapy revisited *Psychotherapy, 28*, 207-217.

- Hemmings, A. (2008). A response to the chapters in Against and For CBT. In R. House & D. Loewenthal (Eds.), *Against and For CBT: Towards a constructive dialogue*. London: PCCS Books.
- Henry, W. E. (1966). Some observations of the lives of healers. *Human Development, 9*, 47-56.
- Henry, W. P. (1998). Science, politics, and the politics of science: The use and misuse of empirically validated treatment research. *Psychotherapy Research, 8*, 126-140.
- Henwood, K., & Pidgeon, N. (1995). Grounded theory and psychological research. *The Psychologist, 8*, 115-118.
- Henwood, K. L., & Pidgeon, N. (2003). Grounded theory in psychological research. In P. Camic, L. Yardley & J. Rhodes (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 131-155). Washington DC: APA Publication.
- Henwood, K. L., & Pidgeon, N. F. (1993). Qualitative research and psychological theorizing. In M. Hammersley (Ed.), *In social research: Philosophy, politics and practice*. London: Sage.
- Heppner, P. P., & Claiborn, C. D. (1989). Social influence research in counseling: A review and critique [Monograph]. *Journal of Counseling Psychology* (36), 365-387.
- Heppner, P. P., Kivlighan, D. M. J., & Wampold, B. E. (1999). *Research design in counseling* (2nd ed.). Pacific Grove, CA: Brooks/Cole.
- Heppner, P. P., Rosenberg, J. I., & Hedgespeth, J. (1992). Three methods in measuring the therapeutic process: Clients' and counselors' constructions of the therapeutic events. *Journal of Counseling Psychology, 39*, 20-31.
- Herman, K. C. (1997). Embracing human science in counseling research. *Counselor Education and Supervision, 36*, 270-283.
- Heron, J. (1996). Co-operative inquiry: Research into the human condition. London: Sage Publications.

- Hertz, R. (Ed.). (1997). *Reflexivity and voice*. Thousand Oaks, California: Sage.
- Heshusius, L. (1994). Freeing ourselves from objectivity: Managing subjectivity or turning toward a participatory mode of consciousness? *Educational Researcher*, 23, 15-22.
- Hiles, D. R. (2002). *Narrative and heuristic approaches to transpersonal research and practice*. Paper presented at the Centre for Counselling and Psychotherapy Education, London.
- Hill, C. E. (1990). Exploratory in-session process research in individual psychotherapy: A review. *Journal of Consulting and Clinical Psychology*, 58(3), 288-294.
- Hill, C. E. (1994). From an experimental to an exploratory naturalistic approach to studying psychotherapy process. In R. L. Russell (Ed.), *Reassessing psychotherapy research* (pp. 144-165). New York: Guilford Press.
- Hill, C. E. (2005). Therapist techniques, client involvement, and the therapeutic relationship: Inextricably intertwined in the therapy process. *Psychotherapy: Theory, Research, Practice, Training*, 42(4), 431-442.
- Hill, C. E. (2007). My personal reactions to Rogers (1957). *Psychotherapy: Theory, Research, Practice, Training*, 44(3), 9-29.
- Hill, C. E., & Corbett, M. M. (1993). A perspective on the history of process and outcome in psychotherapy. *Journal of Counseling Psychology*, 40, 3-24.
- Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapeutic processes and outcome. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behavior change* (5th Edition ed., pp. 84-135). New York: Wiley and Sons.
- Hill, C. E., Nutt, E. A., & Jackson, S. (1994). Trends in psychotherapy process research: Samples, measures, researchers, and classic publications. *Journal of Counseling Psychology*, 41(3), 364-377.

- Hill, C. E., Nutt-Williams, E., Heaton, K. J., Thompson, B. J., & Rhodes, R. H. (1996). Therapist retrospective recall of impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology, 43*, 207-217.
- Hill, C. E., & O'Grady, K. E. (1985). List of therapist intentions: Illustrated in a single case and with therapists of varying theoretical orientations. *Journal of Counseling Psychology, 32*, 3-22.
- Hill, D. C. (1986). The relationship of process to outcome in brief expressive psychotherapy. University of Arizona, Arizona.
- Hillerbrand, E. T., & Claiborn, C. D. (1990). Examining reasoning skill differences between expert and novice counselors. *Journal of Counseling and Development, 68*, 684-691.
- Hinshelwood, R. D. (1989). *A dictionary of Kleinian thought*. London: Free Association Books.
- Hitchcock, G., & Hughes, D. (1989). Research and the teacher A qualitative introduction to school-based research. London: Routledge.
- Hoffer, W. (1956). Transference and transference neurosis. *International Journal of Psycho-Analysis, 37*, 377-379.
- Hogan, R., & Smither, R. (2008). *Personalities: Theories and applications* (2nd ed.). Tulsa, OK: Hogan Assessment Systems.
- Hollingsworth, M. A., & Fassinger, R. E. (2002). The role of faculty mentors in the research training of counseling psychology doctoral students. *Journal of Counseling Psychology, 49*, 324-330.
- Holmes, J. (2001). The search for the secure base: Attachment theory and psychotherapy. London: Routledge.
- Honos-Webb, L., Stiles, W. B., Greenberg, L. S., & Goldman, R. (1998). Assimilation analysis of process-experiential psychotherapy: A comparison of two cases. *Psychotherapy Research, 8*, 264-286.

- Horowitz, L. M., Sampson, H., Siegelman, E., Wolfson, A., & Weiss, J. (1975). On the identification of warded-off mental contents. *Journal of Abnormal Psychology, 84*, 545-588.
- Horvath, A. O. (1981). An exploratory study of the working alliance: Its measurement and relationship to outcome. Unpublished doctoral dissertation. University of British Columbia.
- Horvath, A. O. (1994). Research on the alliance. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. 259-287). New York: Wiley.
- Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61*, 561-573.
- Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37-70). New York: Oxford University Press.
- Horvath, A. O., & Greenberg, L. S. (Eds.). (1994). *The working alliance: theory, research and practice*. New York: John Wiley & Sons.
- Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, 139-149.
- Hoshmand, L. T., & Polkinghorne, D. E. (1992). Redefining the science-practice relationship and professional training. *American Psychologist, 47*, 55-66.
- House, R. (2003). *Therapy beyond modernity: Deconstructing and transcending profession-centred therapy* London: Karnac.
- Howard, G. S. (1983). Toward methodological pluralism. *Journal of Counseling Psychology, 30*(1), 19-21.
- Howard, G. S. (1984). A modern proposal for a revision of strategies for counseling research. *Journal of Counseling Psychology, 31*, 430-442.

- Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose-response relationship in psychotherapy. *The American Psychologist*, 41, 159-164.
- Howe, D. (1996). Client experiences of counselling and treatment interventions: A qualitative study of family views of family therapy. *British Journal of Guidance and Counselling*, 24(3), 367-378.
- Hubble, M. A., Duncan, B. L., & Miller, S. D. (Eds.). (1999). *The heart and soul of change*. Washington, D.C.: APA Press.
- Hudson, J. D. (1997). A model of professional knowledge for social work practice. *Australian Social Work*, 50(3), 35-44.
- Husserl, E. (1970). *The crisis of the European sciences and transcendental phenomenology* (D. Carr, Trans.), Evanston, IL: North Western University Press.
- Hycner, R. (1991). Between person and person: Towards a dialogical psychotherapy. Highland, NY: Gestalt Journal Press.
- Hycner, R., & Jacobs, L. (1995). *The healing relationship in gestalt therapy: A dialogic/ self psychology approach*. Cleveland, Ohio: Gestalt Institute of Cleveland Press.
- Iannotti, R. J. (1975). The nature and measurement of empathy in children *The Counseling Psychologist*, 5, 21-25.
- Imel, Z. E., & Wampold, B. E. (2008). The importance of treatment and the science of common factors in psychotherapy. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (4th ed., pp. 249-262). New York: John Wiley & Sons Inc.
- Imre, R. W. (1985). Tacit knowledge in social work research and practice. *Smith College Studies in Social Work*, 55(2), 137-149.
- Irving, P., & Dickson, D. (2006). A re-conceptualization of Rogers' core conditions: Implications for research, practice and training. *International Journal for the Advancement of Counselling*, 28, 183-194.

- Ivey, A., & Authier, J. (1971). *Micro-counseling: Innovations in interview training, counselling, psychotherapy and psycho-education*. Springfield: C. C. Thomas.
- Ivey, A. E., & Authier, J. (1978). *Micro-counseling: Innovations in interviewing, counseling, psychotherapy, and psycho-education*. (2nd ed.). Oxford, England: Charles C Thomas.
- Ivey, A., & Ivey, M. (2007). *Intentional interviewing and counselling* (6th ed.). Belmont, CA: Thomson-Brooks & Cole.
- Jacobs, M. (2004). *Psychodynamic counselling in action*. London: Sage.
- Jacobs, T. (1991). *The use of the self: Countertransference and communication in the analytic setting*. Madison, CT: International Universities Press.
- Jacobson, N. S., Martell, C. R., & Dimidjian, S. (2001). Behavioral activation treatment for depression: Returning to contextual roots. *Clinical Psychology Science and Practice*, 8, 255-270.
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59, 12-19.
- Jaenicke, C. (2007). *The risk of relatedness: Intersubjectivity theory in clinical practice*. Maryland, USA: Jason Aronson.
- Jaffe, D. (1986). Empathy, counter-identification, countertransference. *Psychoanalytic Quarterly*, 55, 215-243.
- James, H. (1991). *Pragmatism*. New York: Prometheus Books.
- James, W. (1904). *What is pragmatism?* Writings 1902-1920, Library of America.
- Janesick, V. T. (2000). The choreography of qualitative research design. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 379-399). Thousand Oaks California: Sage.

- Jennings, B. (1993). Healing the self: The moral meaning of relationships in rehabilitation. *American Journal of Physical Medicine and Rehabilitation*, 72, 401-404.
- Jennings, L., D'Rozario, V., Goh, M., Sovereign, A., Brogger, M. L., & Skovholt, T. M. (2008). Psychotherapy expertise in Singapore: A qualitative investigation. *Psychotherapy Research*, 18, 508-522.
- Jennings, L., Goh, M., Skovholt, T. M., Hanson, M., & Banerjee-Stevens, D. (2003). Multiple factors in the development of the expert counselor and therapist. *Journal of Career Development*, 30(1), 59-72.
- Jennings, L., Hanson, M., Skovholt, T. M., & Grier, T. (2005). Searching for mastery. *Journal of Mental Health Counseling*, 27(1), 19-31.
- Jennings, L., & Skovholt, T. M. (1999). The cognitive, emotional and relational characteristics of master therapists. *Journal of Counseling Psychology*, 46, 3-11.
- Jennings, L., & Skovholt, T. M. (2004). The cognitive, emotional, and relational characteristics of master therapists. In T. M. Skovholt & L. Jennings (Eds.), *Master therapists: Exploring expertise in therapy and counseling* (pp. 31-52). Boston, MA: Allyn & Bacon.
- Joanides, C. J., Brigham, L., & Joanning, H. (1997). Co-creating a more cooperative client-therapist relationship through a debriefing process. *American Journal of Family Therapy*, 25(2), 139-150.
- Johansson, S. (2004). Why change the subject? *Target*, 16(1), 29-52.
- Johns, C. (1995). Framing learning through reflection within Carper's fundamental ways of knowing in nursing. *Journal of Advanced Nursing* 22(2), 226-234.
- Johnson, B. (2007). Transformational supervision: When supervisors mentor. *Professional Psychology: Research and Practice*, 38(3), 259-267.
- Johnson, B., & Christensen, L. (2004). Educational research: Quantitative, qualitative, and mixed approaches, Research edition (2nd ed.). Boston: Allyn & Bacon.

- Johnson, C. V., Hayes, J. A., & Wade, N. G. (2007). Psychotherapy with troubled spirits: A qualitative investigation. *Psychotherapy Research* 17, 450-460.
- Johnson, M. (1987). *The body in the mind*. Chicago: University of Chicago Press.
- Johnson, W. B. (2003). A framework for conceptualizing competence to mentor. *Ethics and Behavior*, 13, 127-151.
- Johnson, W. B. (2006). On being a mentor: A guide for higher education faculty. Mahwah, NJ: Erlbaum.
- Johnson, W. B., & Campbell, C. D. (2004). Character and fitness requirements for professional psychologists: Training Directors' perspectives. *Professional Psychology: Research and Practice*, 35(4), 405-411.
- Johnson, W. B., & Huwe, J. M. (2003). *Getting mentored in graduate school*. Washington, DC: American Psychological Association.
- Johnson, W. B., Koch, C., Fallow, G. O., & Huwe, J. M. (2000). Prevalence of mentoring in clinical versus experimental doctoral programs: Survey findings, implications, and recommendations *Psychotherapy*, 37, 325-334.
- Jones, A. C. (2004). Transference and countertransference. *Perspectives in Psychiatric Care*, 40(1), 13-19.
- Jones, S., & Hill, K. (2003). Understanding patterns of commitment: Student motivation for community service. *Journal of Higher Education*, 74(5), 516-539.
- Jordan, J. V. (1986). The meaning of mutuality. *Work in Progress*, 23. Wellesley, MA: Stone Center Working Paper Series.
- Jordan, J. V. (1995). A relational approach to psychotherapy. *Women & Therapy*, 16(4), 51 - 61.
- Jordan, J. V. (2000). The role of mutual empathy in relational/cultural therapy. *Journal of Clinical Psychology*, 56(8), 1005-1016.

- Jordan, J. V. (2009). *Relational-cultural therapy (Theories of psychotherapy)*. New York: American Psychological Association.
- Jordan, J. V., Kaplan, A. G., Miller, J. B., Stiver, I. P., & Surrey, J. L. (1991). *Women's growth in connection: Writings from the Stone Center*. New York: The Guilford Press.
- Jordan, J. V., Walker, M., & Hartling, L. M. (Eds.). (2004). The complexity of connection: Writings from the Stone Center's Jean Baker Miller Training Institute. New York: Guilford Press.
- Jørgensen, C. R. (2004). Active ingredients in individual psychotherapy: Searching for common factors. *Psychoanalytic Psychology*, 21(4), 516-540.
- Josefowitz, N., & Myran, D. (2005). Towards a person-centred cognitive behaviour therapy *Counselling Psychology Quarterly*, 18(4), 329 - 336.
- Jourard, T., & Landsman, S. M. (1980). *Healthy personality: An approach from the viewpoint of humanistic psychology* (4th ed.). New York: Macmillan.
- Jung, C. (1922). *Analytic psychology*. London: Balliere.
- Jung, C. G. (1912). *Psychology of the unconscious*. London: Kegan Paul Trench & Trubner.
- Jung, C. G. (1933). *Modern man in search of a soul*. New York: Harcourt, Brace and World.
- Kabat-Zinn, J. (2005). *Wherever you go, there you are*. New York: Hyperion Books.
- Kagan, N. (1975). Interpersonal process recall: A method for influencing human interaction.
- Kahn, E., & Rachman, A. (2000). Carl Rogers and Heinz Kohut: A historical perspective. *Psychoanalytic Psychology*, 17(2), 294-312.
- Kant, I. (1966). *Critique of pure reason*. Garden City, NY: Doubleday (Original work published 1781).

- Kapferer, B. (1986). Performance and the structure of meaning and experience. In V.W. Turner & E. M. Bruner (Eds.), *The anthropology of experience* (pp. 188-203). Urbana: University of Illinois Press.
- Kaslow, F., Cooper, B., & Linsenberg, M. (1979). Family therapist authenticity as a key factor in outcome. *Contemporary Family Therapy*, 1(2), 184-199.
- Kazdin, A. E. (1999). The meanings and measurement of clinical significance. *Journal of Counseling and Clinical Psychology*, 67 (332-339).
- Kazdin, A. E. (2002). *Research design in clinical psychology* (4th ed.). Boston: Allyn & Bacon.
- Kazdin, A. E. (2005). Treatment outcomes, common factors, and continued neglect of mechanisms of change. *Clinical Psychology: Science and Practice*, 12, 184-188.
- Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology*, 3, 1-27.
- Kemmis, S. (1985). Action research and the politics of reflection. In D. Boud, R. Keogh & D. Walker (Eds.), *Reflection: Turning experience into learning* (pp. 139 -163). London: Kogan Page.
- Kiesler, D. (1971). Patient experiencing level and successful outcome in individual psychotherapy of schizophrenics and psychoneurotics. *Journal of Consulting and Clinical Psychology*, 37, 370-385.
- Kiesler, D. J. (1966). Some myths of psychotherapy research and the search for a paradigm. *Psychological Bulletin*, 65, 110-136.
- Kiesler, D. J. (1973). *The process of psychotherapy*. New York: Aldine.
- Kiesler, D. J. (1983). The 1982 interpersonal circle: A taxonomy for complementarity in human transactions. *Psychological Review*, 90, 185-214.

- Kiesler, D. J. (1988). Therapeutic meta-communication: Therapist impact disclosure as feedback in psychotherapy. Palo Alto, CA: Consulting Psychologist's Press.
- Kiesler, D. J., & Strupp, H. H. (2006). The process of psychotherapy: Empirical foundations and systems of analysis. New Jersey: Aldine Transaction.
- Kihlburg, R. R., Nathan, E. N., & Thoreson, R. W. (Eds.). (1986). *Professionals in distress: Issues, syndromes and solutions in psychology*. Washington, DC: American Psychological Association.
- Kihlstrom, J. F. (2002). To honor Kraepelin...From symptoms to pathology in the diagnosis of mental illness. In L. E. Beutler & M. L. Malik (Eds.), *Rethinking the DSM: A psychological perspective*. Washington, DC: American Psychological Association.
- King, Jnr. M.L. (1964). *Why can't we wait?* Alabama: Signet Books.
- King, N. (1994). The qualitative research interview. In C. Cassell & G. Symon (Eds.), *Qualitative methods in organizational research: A practical guide*. London: Sage.
- King, N. J., & Ollendick, T. H. (2000). In defense of empirically supported psychological interventions and the scientist-practitioner model: a response to Andrews. *Australian Psychologist*, 35(1), 64.
- Kinsella, E. A. (2007). Advanced topics in reflective practice. In A. Bossers, M. B. Bezzina, S. Hobson, A. Kinsella, A. MacPhail., S. Schurr, T. Mosa, L. Rolleman, K. Ferguson, S. Deluca, J. Macnab & K. Jenkins (Eds.), *Advanced topics in reflective practice*: University of Western Ontario, Faculty of Health Sciences & The Ontario Ministry of Health and Long Term Care.
- Kirschenbaum, H., & Jourdan, A. (2005). The current status of Carl Rogers and the person-centered approach. *Psychotherapy: Theory, Research, Practice, Training*, 42(1), 37-51.

- Kivlighan, D. M. J., & Quigley, S. T. (1991). Dimensions used by experienced and novice group therapists to conceptualize group processes. *Journal of Counseling Psychology, 38*, 415-423.
- Klein, D. F. (1996). Preventing hung juries about therapy studies. *Journal of Consulting and Clinical Psychology and Clinical Psychology, 64*(1), 81-87.
- Klein, M. H., Mathieu-Coughlan, P., & Kiesler, D. J. (1987). The experiencing scales. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 21-71). New York: Guilford.
- Klein, M. J., & Elliott, R. (2006). Client accounts of personal change in process-experiential psychotherapy: A methodologically pluralistic approach. *Psychotherapy Research, 16*(1), 91-105.
- Klein, W. C., & Bloom, M. (1995). Practice wisdom. *Social Work, 40*(6), 799-807.
- Knox, S. (2008). Gifts in psychotherapy: Practice review and recommendations. *Psychotherapy: Theory, Research, Practice, Training, 45*, 103-110.
- Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology, 44*(3), 274-283.
- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.
- Kohut, H. (1982). Introspection, empathy, and the semi-circle of mental health. *International Journal of Psychoanalysis, 63*, 395-407.
- Kohut, H. (Ed.). (1985). *Self psychology and the humanities*. New York: WW Norton & Company.

- Kolden, G. G. (1996). Change in early sessions of dynamic therapy: Universal processes and the generic model of psychotherapy. *Journal of Consulting and Clinical Psychology, 64*, 489-496.
- Kopp, S. (1969). The Zaddik. *Psychology Today, 2*(12), 6.
- Kopta, S. M., Lueger, R. J., Saunders, S. M., & Howard, K. I. (1999). Individual psychotherapy outcome and process research: Challenges leading to greater turmoil or a positive transition. *Annual Review of Psychology, 50*, 441-469.
- Kovel, J. (1976). A complete guide to therapy: From psychoanalysis to behavior modification. New York: Pantheon Books.
- Kram, K. E. (1985). Mentoring at work: Developmental relationships in organizational life. Glenview, IL: Scott Foresman.
- Krause, M. S., & Lutz, W. (2009). Process transforms inputs to determine outcomes: Therapists are responsible for managing process. *Clinical Psychology: Science and Practice, 16*(1), 73-81.
- Krill, D. F. (1990). Practice wisdom: A guide for helping professionals. Newbury Park: Sage.
- Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., et al. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy. *Journal of Consulting and Clinical Psychology, 64*, 532-539.
- Kuenzli, F. (2006). Inviting reflexivity into the therapy room: How therapists think in practice. New York: University Press of America Inc.
- Kuhn, T. S. (1962). *The structure of scientific revolutions*. Chicago: University of Chicago Press.
- Kuhnlein, I. (1999). Psychotherapy as a process of transformation: The analysis of post-therapeutic autobiographical narrations. *Psychotherapy Research, 9*, 274-288.
- Kuzel, A. (1992). Sampling in qualitative inquiry. In B. Crabtree & W. M. ((Eds.), *Doing qualitative research* (pp. 31-44). London: Sage.

- Kvale, S. (1995). The social construction of validity. *Qualitative Inquiry*, 1(1), 19-40.
- Kvale, S. (1996). Interviews: An introduction to qualitative research interviewing. Thousand Oaks, CA: Sage Publications.
- Lagache, D. (1953). Some aspects of transference. *International Journal of Psycho-Analysis*, 34, 1-10.
- Lakoff, G. (1987). Women, fire, and dangerous things: What categories reveal about the mind. Chicago: University of Chicago Press.
- Lambert, M., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 143-189). New York: John Wiley.
- Lambert, M., Weber, F. D., & Sykes, J. D. (1993). *Psychotherapy versus placebo therapies: A review of the meta-analytic literature*. Paper presented at the Poster Session at the annual meeting of the Western Psychological Association.
- Lambert, M. J. (1986). Implications of psychotherapy outcome research for eclectic psychotherapy. In J. C. Norcross (Ed.), *Handbook of eclectic psychotherapy*. New York: Bruner Mazel.
- Lambert, M. J. (1992). Implications of outcome research for psychotherapy integration. In J. C. Norcross & M. R. Goldstein (Eds.), *Handbook of psychotherapy integration* (pp. 94-129.). New York: Basic Books.
- Lambert, M. J., & Asay, T. P. (1984). Patient characteristics and their relationship to psychotherapy outcome. In M. Herson, L. Michelson & A.S. Bellack (Eds.), *Issues in psychotherapy research* (pp. 313-359). New York: Plenum Press.
- Lambert, M. J., & Baldwin, S. A. (2009). Some observations on studying therapists instead of treatment packages. *Clinical Psychology: Science and Practice*, 16(1), 82-85.
- Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 357-361.

- Lambert, M. J., & Barley, D. E. (2002). Research summary on the therapeutic relationship and psychotherapy outcome. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions to responsiveness to patients* (pp. 17-32). New York: Oxford University Press.
- Lambert, M. J., & Bergin, A. E. (1994). Achievements and limitations of psychotherapy research. In D. K. Freedheim (Ed.), *History of psychotherapy: A century of change* (pp. 360-390). Washington, DC: American Psychological Association.
- Lambert, M. J., DeJulio, S. J., & Stein, D. M. (1978). Therapist interpersonal skills: Process, outcome, methodological considerations, and recommendations for future research. *Psychological Bulletin*, 85, 467-489.
- Lambert, M. J., & Hill, C. E. (1994). Assessing psychotherapy outcomes and processes In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 72-113). New York: John Wiley.
- Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. Lambert (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behavior change* (5 ed.). New York: Wiley.
- Lambert, M. J., & Okiishi, J. C. (1997). The effects of the individual psychotherapist and implications for future research. *Clinical Psychology: Science and Practice*, 4, 66-75.
- Lambert, M. J., Shapiro, D. A., & Bergin, A. E. (1986). The effectiveness of psychotherapy In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (pp. 157-212). New York: Wiley.
- Landis, C. (1938). Statistical evaluation of psychotherapeutic methods. In S. E. Hinselwood (Ed.), *Concepts and problems of psychotherapy* (pp. 155-165). New York: Columbia University Press.
- Latour, B., & Woolgar, S. (1986). *Laboratory life: the construction of scientific facts*. Princeton, N.J.: Princeton University Press.

- Lawson, C., & Lorenzi, E. (1999). Collective learning: Tacit knowledge and regional innovative capacity. *Regional Studies*, 33(4), 305-317.
- Lawson, H. (1985). *Reflexivity: the post-modern predicament*. London: Hutchinson.
- Lazarus, A. A. (1989). *The practice of multimodal therapy*. Baltimore: Johns Hopkins University Press.
- Leitner, L. M. (1995). The terrors of cognition: On the experiential validity of personal construct theory. In D. Bannister (Ed.), *Issues and approaches in personal construct theory* (pp. 83-103). London: Academic Press.
- Leonard, D., & Sensiper, S. (1998). The role of tacit knowledge in group innovation. *California Management Review*, 40(3), 112-132.
- Lerner, B. (1972). *Therapy in the ghetto*. Baltimore: John Hopkins University.
- Levant, R. F. (2005). Evidence-based practice in psychotherapy. *Monitor on Psychology*, 36(2), 5.
- Leventhal, H., & Cleary, P. D. (1980). The smoking problem: A review of the research and theory in behavioral risk modification. *Psychological Bulletin*, 88, 370-405.
- Levinson, D. J., Sharaf, M. R., & Gilbert, D. C. (1966). Intraception: Evaluation of a concept. In G. J. DiRenzo (Ed.), *Concepts, theory and explanation in the behavioral sciences* (pp. 116-135). New York: Random House.
- Lévi-Strauss, C. (1966). *The savage mind*. Chicago: Chicago University Press.
- Levitt, H., Butler, M., & Hill, T. (2006). What clients find helpful in psychotherapy: Developing principles for facilitating moment-to-moment change. *Journal of Counseling Psychology*, 53, 314-324.
- Levitt, H. M., & Rennie, D. L. (2004). Narrative activity: Clients' and therapists' intentions in the process of narration. In L. E. Angus (Ed.),

The handbook of narrative and psychotherapy: Practice, theory and research (pp. 299-313). Thousand Oaks, CA: Sage.

- Lewinsohn, P. M., & Graf, M. (1973). Pleasant activities and depression. *Journal of Consulting and Clinical Psychology & Health* (41), 261-268.
- Liang, B., Tracy, A. J., Taylor, C. A., & Williams, L. M. (2002). Mentoring college-age women: A relational approach. *American Journal of Community Psychology* 30, 271-288.
- Lichtenberg, J. W., & Wampold, B. E. (2002). Closing comments on counseling psychology's principles of empirically-supported interventions. *The Counselling Psychologist*, 30, 309-313.
- Lietaer, G. (1984). Unconditional positive regard: A controversial basic attitude in client centered therapy. In R. F. Levant & J. M. Shlein (Eds.), *Client centered therapy and the person centered approach: New directions in theory, research and practice* (pp. 344-364). New York: Praeger.
- Lietaer, G. (1993). Authenticity, congruence and transparency. In D. Brazier (Ed.), *Beyond Carl Rogers* (pp. 17-46). London: Constable.
- Lincoln, Y., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park: Sage Publications.
- Lincoln, Y. S. (1990). Toward a categorized imperative for qualitative research. In E. Eisner & A. Peshkin (Eds.), *Qualitative inquiry in education: The continuing debate* (pp. 277 - 295). New York: Teachers College Press.
- Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford.
- Lipps, T. (1885). *Psychological studies* (H. C. Sanborn, Trans. 2nd ed.). Baltimore: Williams & Wilkins.
- Livingston, M. L. (1999). Vulnerability, tenderness and the experience of selfobject relationship: A self psychological view of deepening curative process in group psychotherapy. *International Journal of Group Psychotherapy*, 49, 19-40.

- Livingston, M. L. (2009). Sustained empathic focus and its application in the treatment of couples *Clinical Social Work Journal*, 3 (3), 183-189.
- Livingston, M. S. (1975). On barriers, contempt and the "vulnerable moment" in group psychotherapy, *Group Therapy*. NY Stratton: Intercontinental Medical Books.
- Livingston, M. S. (2001). Self psychology, dreams and group psychotherapy: Working in the play space *Group*, 25(1-2), 15-26.
- Llewelyn, S. P., & Hardy, G. (2001). Process research in the practice of psychological therapy. *British Journal of Clinical Psychology*, 40, 1-21.
- Locke, T. F., & Covell, A. J. (1997). Characterizing expert psychologist behavior: Implications from selected expertise literature. *Educational Psychology Review*, 9, 239-249.
- Loewenstein, E. A. (1992). The Freudian case history. *Psychoanalytic Psychology*, 9, 49-59.
- Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: A conceptual model. *The Counseling Psychologist*, 10, 3-42.
- Lomas, P. (1993). Cultivating intuition: An introduction to psychotherapy. Northvale, NJ: Jason Aronson.
- London, P. (1988). Metamorphosis in psychotherapy: Slouching toward Integration. *Journal of Integrative and Eclectic Psychotherapy*, 7, 3-12.
- Long, C. G., & Hollin, C. R. (1997). The scientist-practitioner model in clinical psychology: A critique. *Clinical Psychology and Psychotherapy*, 4, 75-83.
- Lopez, F. G. (1995). Contemporary attachment theory: An introduction with implications for counseling psychology. . *The Counseling Psychologist*, 23, 395-415.
- Loseke, D. R. (2003). Thinking about social problems: An introduction to constructionist perspectives, (2 ed.). New York: Aldine DeGruyter.

- Lower, R., Escoll, P., & Huyster, H. (1972). Bases for judgments of analyzability. *Journal of the American Psychoanalytic Association*, 20, 610-621.
- Luborsky, L. (1976). Helping alliances in psychotherapy: The groundwork for a study of their relationship to its outcome. In J. L. Claghorn (Ed.), *Successful psychotherapy* (pp. 92-116). New York: Brunner/Mazel.
- Luborsky, L. (1990). Theory and technique in dynamic psychotherapy: Curative factors and training therapists to maximize them. *Psychotherapy and Psychomatics*, 53, 50-47.
- Luborsky, L. (1995). Are common factors across different psychotherapies the main explanation for the Dodo bird verdict that "everyone has won so all must have prizes"? *Clinical Psychology: Science and Practice*, 2, 106-109.
- Luborsky, L., Barber, J. P., & Crits-Christoph, P. (1990). Theory-based research for understanding the process of dynamic psychotherapy. *Journal of Consulting and Clinical Psychology*, 58(3), 281-287.
- Luborsky, L., Crits-Christoph, P., & Mellon, J. (1986). The advent of objective measures of transference. *Journal of Consulting and Clinical Psychology*, 54(1), 39-47.
- Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). *Who will benefit from psychotherapy? Predicting therapeutic outcomes*. New York: Basic Books.
- Luborsky, L., Graff, H., Pulver, S., & Curtis, H. (1973). A clinical-quantitative examination of consensus on the concept of transference. *Archives General Psychiatry*, 29, 69-75.
- Luborsky, L., McLellan, A. T., Woody, G. E., O'Brien, C. P., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry*, 42, 602-611.
- Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "Everyone has won and all must have prizes"? *Archive of General Psychiatry*, 32, 995-1008.

- Luchins, A. S. (1948). Problem-centered training in the development of the clinician *American Psychologist*, 3(6), 203-205
- Lyddon, W. J. (1990). First- and second-order change: Implications for rationalist and constructivist cognitive therapies. *Journal of Counseling & Development*, 69, 122-127.
- Lyons-Ruth, K. (1998). Implicit relational knowing: It's role in development and psychoanalytic treatment. *Infant Mental Health Journal*, 19(3), 282-289.
- Lyotard, J. F. (1979). *The postmodern condition: A report on knowledge*. Manchester: Manchester University Press.
- Macaskill, N. D. (1988). Personal therapy in the training of the psychotherapist: Is it effective? *British Journal of Psychotherapy*, 4(3), 219-226.
- Macmurray, J. (1957). *Persons in relation*. London: Faber.
- Mahler, M., Pine, F., & Bergman, A., Basic Books, New York. (1975). *The psychological birth of the human infant*. New York: Basic Books.
- Mahoney, M. J. (1997). Psychotherapists' personal problems and self-care patterns. *Professional Psychology: Research and Practice*, 28, 14-16.
- Mahrer, A. R. (1983). *Experiential psychotherapy: Basic practices*. Ottawa: University of Ottawa Press.
- Mahrer, A. R. (1985). Psychotherapeutic change: An alternative approach to meaning and measurement. New York: W. W. Norton & Co Inc.
- Mahrer, A. R. (1988). Research and clinical applications of "good moments" in psychotherapy. *Journal of Integrative and Eclectic Psychotherapy*, 7, 81-93.
- Mahrer, A. R. (1997). Empathy as therapeutic-client alignment. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 187-213). Washington, D.C.: American Psychological Association.

- Mahrer, A. R., & Nadler, W. P. (1986). Good moments in psychotherapy: A preliminary review, a list, and some promising research avenues. *Journal of Consulting and Clinical Psychology, 54*(1), 10-15.
- Mahrer, A. R., Nadler, W. P., Sterner, I., & White, M. V. (1989). Patterns of organization and sequencing of "good moments" in psychotherapy sessions. *Journal of Integrative and Eclectic Psychotherapy, 8*, 125-139.
- Maione, P. V., & Chenail, R. J. (1999). Qualitative inquiry in psychotherapy: Research on the common factors. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart and soul of change: The role of common factors in psychotherapy* (pp. 57-88). Washington, DC: American Psychological Association.
- Malone, T. P., & Malone, P. T. (1992). The windows of experience, the art of wholeness: Experiential psychotherapy and the emergent self. New York: Simon and Schuster.
- Malterud, K. (2002). Reflexivity and meta-positions: Strategies for appraisal of clinical evidence. *Journal of Evaluation in Clinical Practice, 8*(2), 121 - 126.
- Maluccio, A. (1979). Learning from clients: Interpersonal helping as viewed by clients and social workers. New York Free Press/Macmillan.
- Marcel, M. (1971). *The philosophy of existence*. Philadelphia: University of Pennsylvania Press.
- Margison, F., Barkham, M., Evans, C., McGrath, G., Mellor-Clark, J., Audin, K., et al. (2000). Measurement and psychotherapy: Evidence based practice and practice based evidence *British Journal of Psychiatry 177*, 123-130.
- Margulies, A. (1993). The empathic imagination: Empathy and inscapes. *Journal of American Academy of Psychoanalysis, 21*, 513-524.
- Markowitz, J. C., & Swartz, H. A. (2006). Case formulation in interpersonal psychotherapy of depression. In T.D. Eells (Ed.), *Handbook of*

psychotherapy case formulation (pp. 221-251). New York: The Guilford Press.

Marshall, J. (1986). Exploring the experiences of women managers. In S. Wilkinson (Ed.), *Feminist social psychology: Developing theory and practice* (pp. 193-201). Milton Keynes: Open University Press.

Marshall, M. N. (1996). The key informant technique. *Family Practice*, 13, 92-97.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review *Journal of Consulting and Clinical Psychology* 68, 438-450.

Martin, J., Martin, W., & Slemon, A. G. (1989). Cognitive-meditational models of action-act sequences in counseling. *Journal of Counseling Psychology*, 36, 8-16.

Martin, J., Sleman, A., Hiebert, B., Hallberg, E., & Cummings, A. (1989). Conceptualizations of novice and experienced counsellors. *Journal of Counseling Psychology*, 36(4), 395-400.

Martin, J., & Stelmazonek, K. (1988). Participants' identification of and recall of important events in counselling *Journal of Counseling Psychology*, 34, 251-260.

Maslow, A. (1970). *Motivation and personality*. New York: Harper & Row.

Maslow, A. H. (1967). Self-actualizing and beyond. In J. F. T. Bugental (Ed.), *Challenges of humanistic psychology*. Washington: McGraw-Hill.

Mathieu-Coughlan, P., & Klein, M. H. (1984). Experiential psychotherapy: Key events in client-centered interaction. In L. N. Rice & L. S. Greenberg (Eds.), *Patterns of change* (pp. 194-212). New York: Guilford.

May, R. (1950). *The meaning of anxiety*. New York: W W Norton.

- Mays, N., & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *British Medical Journal*, 1(320), 50-52.
- McCann, T., & Clark, E. (2005). Using unstructured interviews with participants who have schizophrenia. *Nurse Researcher*, 13(1), 7-18.
- McCleary, R., & Lazarus, R. (1949). Autonomic discrimination without awareness. *Journal of Personality* 18, 171-179.
- McEwan, J., & Duncan, P. (1993). Personal therapy in the training of psychologists. *Canadian Psychology* (34), 186-195.
- McKellar, P. (1957). *Imagination and thinking: A psychological analysis*. New York: Basic Books.
- McKenna, P. A., & Todd, D. M. (1997). Longitudinal utilization of mental health services: A time-line method, nine retrospective accounts, and a preliminary conceptualisation. *Psychotherapy Research*, 7, 383-396.
- McLennan, J. (1999). Becoming an effective psychotherapist or counsellor: Are training and supervision necessary? In C. Feltham (Ed.), *Controversies in psychotherapy and counselling*. London: Sage Publications.
- McLeod, J. (1999). *Practitioner research in counselling*. London: Sage Publications.
- McLeod, J. (2001). *Qualitative research in counselling and psychotherapy*. London: Sage Publications.
- McLeod, J. (2003). *Doing counselling research* (2nd ed.). London: Sage Publications.
- McLeod, J. (2004). Counselling and psychotherapy as cultural work. In L. Tsoi Hoshmand (Ed.), *Culture, psychotherapy and counseling: critical and integrative perspectives* (pp. 47-64). Thousand Oaks, CA,: Sage.
- McLeod, J., & Balamoutsou, S. (2001). A method for qualitative narrative analysis of psychotherapy transcripts. In J. Frommer & D. L. Rennie

(Eds.), *Qualitative psychotherapy research: Methods and methodology*. Lengerich Germany: Pabst Science.

McMahon, M., & Patton, W. (2002). Supervision: Lifelong learning for career counsellor. In M. McMahon & W. Patton (Eds.), *Supervision in the helping professions* (pp. 235-248). French's Forest, New South Wales: Pearson Education.

McMillan, M., & McLeod, J. (2006). Letting Go: The client's experience of relational depth. *Narrative Inquiry*, 5(4), 277-292

Mearns, D. (1997). *Person-centred counselling training*. London: Sage Publications.

Mearns, D. (2003). *Developing person-centred counselling* (2 ed.). London: Sage.

Mearns, D., & Cooper, M. (2005). Working at relational depth in counselling and psychotherapy. London: Sage.

Mearns, D., & Thorne, B. (2007). *Person-centred counselling in action* (3rd ed.). Los Angeles: Sage Publications Ltd.

Meichenbaum, D. (2002). Treating individuals with anger control problems and aggressive behavior: A clinical handbook. Waterloo, Ontario: Institute Press.

Meltzoff, J., & Kornreich, M. (1970). *Research in psychotherapy*. New York: Atherton Press Inc.

Merleau-Ponty, M. (1973). *Adventures of the dialectic* Evanston: Northwestern University Press.

Mertens, D. M., & Ginsberg, P. (2008). Preface. In D. M. Mertens & P. Ginsberg (Eds.), *The handbook of social research ethics* (pp. ix-xiv). Thousand Oaks, CA: Sage Publications.

Messer, S. B. (1992). A critical examination of belief structures in integrative and eclectic psychotherapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 130-165). New York: Basic Books.

- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: A sourcebook of new methods* (2nd ed.). Thousand Oaks, CA: Sage.
- Miller, J. B. (1976). *Toward a new psychology of women*. Boston: Beacon.
- Miller, J. B., Jordan, J. V., Stiver, I. P., Walker, M., Surrey, J., & Eldridge, N. S. (1999). Therapists' authenticity. *Work in Progress No. 82 Stone Center Working Paper Series*.
- Miller, J. B., & Stiver, I. P. (1997). *The healing connection: How women form relationships in therapy and in life*. Boston: Beacon Press.
- Miller, S. D., Duncan, B. L., & Hubble, M. A. (1997). *Escape from Babel*. New York: Norton.
- Miller, W. R., & C'de Baca, J. (2001). Quantum change: When epiphanies and sudden insights transform ordinary lives. New York: Guilford Press.
- Miller, W. R., Taylor, C. A., & West, J. C. (1980). Focused versus broad-spectrum behaviour therapy for problem drinkers. *Journal of Consulting and Clinical Psychology*, 48, 590-601.
- Miller-Pietroni, M. (1999). Containment in theory and practice. *Psychodynamic Counselling*, 4(5), 407-427.
- Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods*, 5(1), 1-10.
- Milne, D., & Paxton, R. (1998). A psychological re-analysis of the scientist-practitioner model. *Clinical Psychology & Psychotherapy*, 5 (4), 216-230
- Minami, T., Wampold, B. E., Serlin, R. C., Hamilton, E. G., Brown, G. S., & Kircher, J. C. (2008). Benchmarking the effectiveness of psychotherapy treatment for adult depression in a managed care environment: A preliminary study. *Journal of Consulting and Clinical Psychology*, 76(1), 116-124.

- Minichiello, V. (1995). *Designing qualitative research*. Paper presented at the CRC Seminar Series, Victoria University of Technology, Qualitative Research Forum.
- Minichiello, V., Aroni, R., Timewell, E., & Alexander, L. (1990). *In-depth interviewing: Researching people*. Hong Kong: Longman Cheshire Pty Limited.
- Mintz, J., Drake, R. E., & Crits-Christoph, P. (1996). Efficacy and effectiveness of psychotherapy: Two paradigms, one science. *The American Psychologist*, 51, 1084-1085.
- Mintz, J., & Luborsky, L. (1971). Segments versus whole sessions: Which is the better unit for psychotherapy process research? *Journal of Abnormal Psychology*, 78, 180-191.
- Moran, D. (2000). *Introduction to phenomenology*. New York: Routledge.
- Morrow, S. L. (2007). Qualitative research in counseling psychology. *The Counseling Psychologist*, 35(2), 209-235.
- Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, 52, 250-260.
- Morrow, S. L., & Smith, M. L. (2000). Qualitative research for counseling psychology. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 199-230). New York: John Wiley.
- Morrow-Bradley, C., & Elliott, R. (1986). Utilization of psychotherapy research by practicing psychotherapists. *American Psychologist*, 41, 188-197.
- Morse J.M. (1999). Qualitative generalizability. *Qualitative Health Research* 9(1), 5-6.
- Moursund, J. P., & Erskine, R. G. (2004). *Integrative psychotherapy: The art and science of relationship*. Pacific Grove, CA: Thomson: Brooks/Cole.

- Moustakas, C. (1967). Heuristic research. In J. F. T. Bugental (Ed.), *Challenges of humanistic psychology* (pp. 101-107). New York: McGraw-Hill.
- Moustakas, C. (1990). Heuristic research: Design, methodology and applications. New York: Sage.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.
- Moustakas, C. (2001). Heuristic research: Design and methodology. In K. J. Schneider, J. F. T. Bugental & J.F. Pierson (Eds.), *The handbook of humanistic psychology: Leading edges in theory, research, and practice* (pp. 263-274). New York: Sage.
- Munhall, P. (2001). Ethical considerations in qualitative research. In P. Munhall (Ed.), *Nursing research: A qualitative perspective* (3rd ed., pp. 537-549). Sudbury, MA: Jones and Bartlett.
- Munro, E. (1998). Understanding social work: An empirical approach. London: The Athlone Press.
- Murray, H. (1938). *Exploration in personality*. New York: Oxford University Press.
- Nathan, P. E., & Gorman, J. M. (2007). *A guide to treatments that work* (3rd ed.). New York: Oxford University Press.
- Nathan, P. E., Stuart, S. P., & Dolan, S. L. (2000). Research on psychotherapy efficacy and effectiveness: Between Scylla and Charybdis? *Psychological Bulletin*, 126, 964-981.
- Neimeyer, R. A. (1995). Constructivist psychotherapies: Features, foundations and future directions. In R. A. Neimeyer & M. J. Mahoney (Eds.), *Constructivism in psychotherapy* (pp. 11-38). Washington, DC: American Psychological Association.
- Neimeyer, R. A. (2009). Constructivist psychotherapy: Distinctive features. London: Routledge.

- Nelson, M., & Poulin, K. (1997). Method of constructivist inquiry. In T. Sexton & B. Griffin (Eds.), *Constructivist thinking in counseling practice* (pp. 157-173). New York: Teachers College Press.
- Newman, S. (1999). Philosophy and teacher education: A reinterpretation of Donald A. Schön's epistemology of reflective practice. London: Avebury.
- Nichols, M. P. (1974). Outcome of brief cathartic psychotherapy. *Journal of Consulting and Clinical Psychology*, 42(3), 403-410.
- Nietzel, M. T., & Fisher, S. G. (1981). Effectiveness of professional and paraprofessional helpers: A comment on Durlak. *Psychological Bulletin*, 89(3), 555-565.
- Nightingale, D. J., & Cromby, J. (Eds.). (1999). *Social constructionist psychology: A critical analysis of theory and practice*. Buckingham: Open University Press.
- Nilsson, C. (2010). A phenomenological approach to practical knowledge in psychotherapy. *Santalka. Filosofija* 18(3), 70-80.
- Norcross, J. C. (1999). A primer on psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 3-23). New York: Oxford University Press.
- Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work*. New York: Oxford University Press.
- Norcross, J. C. (2005). The psychotherapist's own psychotherapy: Educating and developing psychologists. *American Psychologist*, 60(8), 840-850.
- Norcross, J. C., & Goldfried, M. R. (Eds.). (2005). *Handbook of psychotherapy integration* (2nd ed.). New York: Oxford.
- Norcross, J. C., & Grencavage, L. M. (1989). Eclecticism and integration in counselling and psychotherapy: Major themes and obstacle. *British Journal of Guidance and Counselling*, 17(3), 227- 247.
- Norcross, J. C., & Newman, C. (1992). Psychotherapy integration: Setting the context. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 3-46). New York: Basic.

- Norton, L. (1999). The philosophical bases of grounded theory and their implications for research practice. *Nurse Researcher*, 7(1), 31-43.
- Nunberg, H. (1951). Transference and reality. *International Journal of Psycho-Analysis*, 32, 1-9.
- O' Donovan, A., & Dyck, M. (2001). Effective training in clinical and counselling psychology: Not as simple as it sounds. *Australian Psychologist*, 36(2), 92-98.
- O' Hara, M. (1997). Relational empathy: Beyond modernist egocentrism to postmodern holistic contextualism. In A.C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 295-319). Washington: American Psychological Association.
- Obholzer, A., & Zagier Roberts, V. (Eds.). (1994). *The unconscious at work: Individual and organizational stress In the human services*. London: Routledge.
- Ogden, T. (1994). The analytic third: Working with intersubjective clinical facts. *International Journal of Psycho-Analysis*, 75, 3-19.
- Ogden, T. (2004). The analytic third: Implications for psychoanalytic theory and technique. *Psychoanalytic quarterly*, 73(1), 167-195.
- Ogles, B. M., Anderson, T., & Lunnen, K. M. (1999). The contribution of techniques to therapeutic efficacy: Contradictions between research and training. In M. Hubble, B. Duncan & S. Miller (Eds.), *The heart and soul of change*. Washington, DC: American Psychological Association.
- Ogles, B. M., Lambert, M. J., & Craig, D. E. (1991). A comparison of self-help books for coping with loss: Expectations and attributions. *Journal of Counseling Psychology*, 38, 387-393.
- O'Gorman, J. G. (2001). The scientist-practitioner model and its critics Australian Psychologist Special Issue: Training in clinical and counseling psychology, 36, 164-169.
- Olafson, F. A. (2001). *Naturalism and the human condition: Against scientism*. London: Routledge.

- Orange, D. (1995). *Emotional understanding: Studies in psychoanalytic epistemology*. New York: Guilford.
- Orange, D. M., Atwood, G. E., & Stolorow, P. D. (1997). *Working intersubjectively: Contextualism in psychoanalytic practice*. Hillsdale, NJ: The Analytic Press.
- Orlinsky, D., Ambuehl, H., Rønnestad, M. H., Davis, J., Gerin, P., Davis, M., et al. (1999). The development of psychotherapists: Concepts, questions, and methods of a collaborative international study. *Psychotherapy Research*, 9, 127-153.
- Orlinsky, D., & Rønnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth* Washington, DC: American Psychological Association.
- Orlinsky, D., Rønnestad, M. H., Ambuehl, H., Willutzki, U., Botermans, J. F., Cierpka, M., et al. (1999). Psychotherapists' assessments of their development at different career levels. *Psychotherapy*, 36, 203-215.
- Orlinsky, D. E. (1999). The master therapist: Ideal character or clinical fiction? *Journal of Counseling Psychology*, 46, 12-15.
- Orlinsky, D. E., Ambühl, H., Rønnestad, M. H., Davis, J. D., Gerin, P., Davis, M., et al. (1999). The development of psychotherapists: Concepts, questions, and methods of a collaborative international study. *Psychotherapy Research*, 8, 127-153.
- Orlinsky, D. E., Botermans, J. F., & Rønnestad, M. H. (2001). Towards an empirically grounded model of psychotherapy training: Four thousand therapists rate influences on their development. *Australian Psychologist*, 36(2), 139-148
- Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy: Noch einmal. In B. A. E. & G. S.L. (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270-376). New York, NY: John Wiley & Sons.
- Orlinsky, D. E., & Howard, K. I. (1966). *Therapy session report, Forms P and T*. Chicago: Institute of Juvenile Research.

- Orlinsky, D. E., & Howard, K. I. (1986). Process and outcome in psychotherapy. In S. Garfield & A. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed.). New York: Wiley.
- Orlinsky, D. E., & Howard, K. I. (1987). A generic model of psychotherapy. *Journal of Integrative & Eclectic Psychotherapy*, 6(1), 6-27.
- Orlinsky, D. E., Norcross, J. C., Rønnestad, M. H., & Wiseman, H. (2005). Outcomes and impacts of psychotherapists' personal therapy: A research review. In J. D. Geller, J. C. Norcross & D. E. Orlinsky (Eds.), *The psychotherapist's own psychotherapy: Patient and clinician perspectives* (pp. pp. 214-230). New York: Oxford University Press.
- Orlinsky, D. E., Rønnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behavior change* (5th ed., pp. 307-389). New York: John Wiley & Sons.
- Orrum, M. (2004). Counselling psychologists in Western Australia: Roles, functions, settings and professional identity. Curtin University of Technology, Perth.
- O'Sullivan, T. (2005). Some theoretical propositions on the nature of practice wisdom. *Journal of Social Work*, 5(2), 221-242.
- Pachankis, J. E., & Goldfried, M. R. (2007). An integrative, principle-based approach to psychotherapy. In S. Hofmann & J. Weinberger (Eds.), *The art and science of psychotherapy* (pp. 49-68). New York, NY: Routledge.
- Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing psychopathology*. London: Sage.
- Patterson, C. H. (1984). Empathy, warmth, and genuineness in psychotherapy: A review of reviews. *Psychotherapy: Theory, Research, Practice, Training*, 21(4), 431-438.

- Patton, M. Q. (1984). *Qualitative evaluation methods*. London: Sage Publications.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, California: Sage Publications.
- Paul, G. L. (1967). Strategy of outcome research in psychotherapy. *Journal of Consulting Psychology*, 31, 108-119.
- Paulson, B., Truscott, D., & Stuart, J. (1999). Clients' perception of helpful experiences in counseling. *Journal of Counseling Psychology*, 46, 317-324.
- Payne, M. (2009). Knowledge, evidence and the wise person of practice: The example of social work and social care in palliative care. In H. Otto, A. Polutta & H. Ziegler (Eds.), *Evidence-based practice: Modernizing the knowledge base of social work* (pp. 77-94). Farrington Falls: Barbara Budrich.
- Payne, W. L. (1985). A study of emotion: Developing emotional intelligence: self integration; relating to fear, pain and desire (theory, structure of reality, problem-solving, contraction/expansion, tuning in/coming out/letting go). The Union Institute, Cincinnati Ohio, USA.
- Pearson, P. H. (1974). Conceptualizing and measuring openness to experience in the context of psychotherapy. In D. A. Wexler & L. N. Rice (Eds.), *Innovations in client centered therapy* (pp. 139-170). New York: John Wiley.
- Peeters, B. (2004). Tall poppies and egalitarianism in Australian discourse: From key word to cultural value. *English World Wide*, 25(1-25).
- Peirce, C. S. (Ed.). (1955). *Philosophical writings of Peirce*. New York Dover Publications.
- Pepper, S. C. (1942). *World hypotheses: A study in evidence*. Berkeley: University of California Press.

- Phillips, J. R. (1984). Influences on personal growth as viewed by former psychotherapy patients. York University Toronto.
- Pickard, A., & Dixon, P. (2004). The applicability of constructivist user studies: How can constructivist inquiry inform service providers and systems designers? *Information Research*, 9(3), Paper 175.
- Pidgeon, N., & Henwood, K. (1997). Using grounded theory in psychological research. In N. Hayes (Ed.), *Doing qualitative analysis in psychology* (pp. 245-273). Hove, UK: Psychology Press.
- Pizzi, M. (1990). The transformation of HIV infection and AIDS in occupational therapy: Beginning the conversation. *Occupational Therapy in Health Care*, 7(2,3,4), 45-53.
- Plummer, M., & Young, L. E. (2009). Grounded theory and feminist Inquiry: Revitalizing links to the past *Western Journal of Nursing Research*, 20(10), 1-17.
- Polanyi, M. (1958). *Personal knowledge: Towards a post-critical philosophy*. London: Routledge and Kegan Paul.
- Polanyi, M. (1966). *The tacit dimension*. Garden City, New York: Doubleday.
- Polkinghorne, D. E. (1983). *Methodology for the human sciences: Systems of inquiry*. Albany: State University of New York Press.
- Polkinghorne, D. E. (1984). Further extensions of methodological diversity for counseling psychology. *Journal of Counseling Psychology*, 31(4), 416-429.
- Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences* New York: State University of New York Press.
- Polkinghorne, D. E. (1989). Phenomenological research methods. In R. S. Valle & S. Halling (Eds.), *Existential-phenomenological perspectives in psychology* (pp. 41-60). New York: Plenum.
- Polkinghorne, D. E. (1991). *Generalization and qualitative research: Issues of external validity*. Paper presented at the Annual meeting of the AERA, Chicago, April 21 - 25.

- Polkinghorne, D. E. (1999). How can research discover how to do psychotherapy: Traditional research and psychotherapy practice *Journal of Clinical Psychology*, 55 (12), 1429 - 1440.
- Polkinghorne, D. E. (2000). The unconstructed self. *Culture and Psychology*, 6(2), 264-272.
- Polkinghorne, D. E. (2004). Practice and the human sciences: The case for a judgment-based practice of care. New York: State University of New York Press.
- Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology*, 52(2), 137-145.
- Ponterotto, J. (2005). Qualitative research in counseling psychology: A primer in research paradigms and philosophy of science. *Journal of Counseling Psychology*, 52(2), 126-136.
- Ponterotto, J. G. (2002). Qualitative research methods: The fifth force in psychology. *Counseling Psychologist*, 30(3), 394-406.
- Ponterotto, J. G., & Grieger, I. (2007). Effectively communicating qualitative research. *The Counseling Psychologist*, 35, 404-430.
- Porter, E. I. (2000). Setting aside the identity furor: Staying her story-course of same-ness. *Qualitative Inquiry*, 6(2), 238-250.
- Portnoy, D. (1999). Relatedness: Where humanistic and psychoanalytic psychotherapy converge. *Journal of Humanistic Psychology*, 39(1), 19-34.
- Potter, J., & Wetherell, M. (1987). Discourse and social psychology: Beyond attitudes and behaviour. London: Sage.
- Powell, R. A., Symaluk, D. G., & Honey, P. L. (2009). Introduction to learning and behaviour. Pacific Grove: Wadsworth.
- Prigogine, I., & Stengers, I. (1984). *Order out of chaos*. New York: Bantam Books.

- Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice, 19*(3), 276-288.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors *American Psychologist, 47* (9), 1102-1114.
- Punch, K. (1998). Introduction to social research: Quantitative and qualitative approaches. London, UK: Sage Publications.
- Putnam, H. (1983). *Realism and reason. Philosophical papers, vol. 3.* Cambridge: Cambridge University Press.
- Qureshi, A. (2007). I was being myself but being an actor too: The experience of a Black male in interracial psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice, 80* 467-479.
- Rachelson, J., & Clance, P. R. (1980). Attitudes of psychotherapists toward the 1970 APA standards for psychotherapy training. *Professional Psychology: Research and Practice, 11*, 261-267.
- Radeke, J., & Mahoney, M. J. (2000). Comparing the personal lives of psychotherapists and research psychologists. *Professional Psychology: Research and Practice, 31*, 82-84.
- Raimy, V. (Ed.). (1950). *Training in clinical psychology.* New York: Prentice Hall.
- Raskin, N. J. (1949). An objective approach to the study of psychotherapy. *American Scientist, 37*(3).
- Reichertz. (2007). Abduction: The logic of discovery of grounded theory. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 214-228). Los Angeles: Sage, CA.
- Reid, A. (1993). Social justice and the national curriculum *Curriculum Perspectives 12*(4), 14-22.
- Reiff, R. (1968). Social intervention and the problem of psychological analysis. *The American Psychologist, 23*, 524-531.

- Reik, T. (1948). *Listening with the third ear: The inner experience of a psychoanalyst*. New York: Grove Press.
- Reiser, M. F. (1971). Psychological issues in training for research in psychiatry. *Journal of Psychiatric Review*, 8, 531-537.
- Rennie, D. (1994). Clients' deference in psychotherapy. *Journal of Counselling Psychology*, 41(4), 427-437.
- Rennie, D. (2001). The client as a self-aware agent in counselling and psychotherapy. *Counselling and Psychotherapy Research*, 1(2), 82-89.
- Rennie, D. L. (1990). Toward a representation of the client's experience of the psychotherapy. In G. Lietaer, J. Rombauts & R. Van Balen (Eds.), *Client-centered and experiential psychotherapy in the nineties* (pp. 158-172). Leuven, Belgium: Leuven University Press.
- Rennie, D. L. (1992). Qualitative analysis of the client's experience of psychotherapy: The unfolding of reflexivity. In D. L. Rennie & S. G. Toukmanian (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches* (pp. 211-233). Newbury Park, CA: Sage.
- Rennie, D. L. (1998a). Grounded theory methodology: The pressing need for a coherent logic of justification. *Theory and Psychology*, 8(1), 101-120.
- Rennie, D. L. (1998b). *Person-centred counselling: An experiential approach*. London: Sage.
- Rennie, D. L. (2000). Aspects of the client's conscious control of the psychotherapeutic process. *Journal of Psychotherapy Integration*, 10(2), 151-167.
- Rennie, D. L. (2002). Experiencing psychotherapy: Grounded theory studies. In D. J. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 117-144). Washington, DC: American Psychological Association.
- Rennie, D. L. (2004a). Anglo-North American qualitative counseling and psychotherapy research. *Psychotherapy Research*, 14(1), 37-55.

- Rennie, D. L. (2004b). Reflexivity and person-centered counselling. *Journal of Humanistic Psychology, 44*, 182-203.
- Renolds, R. (2007). How does therapy cure? The relational turn in psychotherapy. *Counselling, Psychotherapy, and Health, 3*(2), 127-150.
- Rhodes, R. H., Hill, C. E., Thompson, B. J., & Elliott, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding events. *Journal of Counseling Psychology, 41*(4), 473-483.
- Rice, L., & Greenberg, L. (Eds.). (1984). Patterns of change: An intensive analysis of psychotherapeutic process. New York: Guilford Press.
- Rice, L., & Kerr, L. N. (1986). Measures of client and therapist vocal quality. In L. S. Greenberg & W. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 73-106). New York: Guilford.
- Rice, L. N., & Saperia, E. P. (1984). Task analysis and the resolution of problematic reactions. In L. N. Rice & L. S. Greenberg (Eds.), *Patterns of change* (pp. 29-66). New York: Guilford.
- Richardson, L. (1994). Writing: A method of inquiry. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research*. Thousand Oaks: Sage.
- Richardson, R., & Kramer, E. H. (2006). Abduction as the type of inference that characterizes the development of grounded theory. *Qualitative Research, 6*(4), 497-513.
- Ricks, D. F. (1974). Supershrink: Methods of a therapist judged successful on the basis of adult outcomes of adolescent patients In D. F. Ricks & M. Roff (Eds.), *Life history research in psychopathology* (pp. 275-297). Minneapolis: University of Minnesota Press.
- Rinehart, C. W. (2009). Love and compassion: Their application to healing in psychoanalytic psychotherapy and meta-psychiatry. New York: Hawthorne Printing Company.

- Robbins, S. B., & Jolkovski, M. P. (1987). Managing countertransference feelings: An interactional model using awareness of feeling and theoretical framework.
- Robertson, M. H. B., & Boyle, J. S. (1984). Ethnography: Contributions to nursing research. *Journal of Advanced Nursing*, 9, 43-49.
- Robinson, F. P. (1950). Principles and procedures in student counselling. New York: Harper.
- Rodgers, C. (2002). Defining reflection: Another look at John Dewey and reflective thinking. *Teachers College Record*, 104(4), 842-866.
- Rogawski, A. S. (1982). Current status of brief psychotherapy. *Bulletin of the Menninger Clinic*, 46(4), 331-351.
- Rogers, C. (1951). Client-centered therapy: Its current practice, implications and theory. London: Constable.
- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21(2), 95-103.
- Rogers, C. (1959). A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of a science. Vol. 3: Formulations of the person and the social context*. New York: McGraw Hill.
- Rogers, C. (1961). On becoming a person: A therapist's view of psychotherapy. London: Constable.
- Rogers, C. (1977). On personal power: Inner strength and its revolutionary impact. New York: Delacorte Press.
- Rogers, C. R. (1942). Counseling and psychotherapy: New concepts in practice. Boston: Houghton Mifflin.
- Rogers, C. R. (1949). The attitude and orientation of the counselor in client-centered therapy. *Journal of Consulting Psychology*, 13, 82-94.
- Rogers, C. R. (1952). Client-centered psychotherapy. *Scientific American*, 187, 1-7.

- Rogers, C. R. (1975). Empathy: An unappreciated way of being. *The Counseling Psychologist*, 5(2), 2-10.
- Rogers, C. R. (1980). *A way of being*. Boston: Houghton Mifflin.
- Rogers, C. R. (1986). Client-centered therapy. In I. L. Kutash and A. Wolf (Eds.). *Psychotherapist's Casebook: Theory and technique in the practice of modern therapies*. San Francisco: Jossey-Bass.
- Rogers, C. R., & Dymond, R. F. (Eds.). (1954). *Psychotherapy and personality change: Coordinated research studies in the client-centered approach*. Chicago: University of Chicago Press.
- Rogers, C., R., Gendlin, E. T., Kiesler, D. J., & Traux, C. B. (Eds.). (1967). *The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics*. Madison, WI: University of Wisconsin Press.
- Rolfe, G. (2005). Evidence, memory and truth: Towards a deconstructive validation of reflective practice. In C. Johns & D. Freshwater (Eds.), *Transforming nursing through reflective practice*. Oxford: Blackwell Publishing Ltd.
- Rønnestad, M. H., & Skovholt, T. M. (2001). Learning arenas for professional development: Retrospective accounts of senior psychotherapists. *Professional Psychology Research and Practice*, 32(2), 181-187.
- Rønnestad, M. H., & Skovholt, T. M. (1991). A model of the professional development and stagnation of therapists and counselors. *Journal of the Norwegian Psychological Association*, 28, 555-567.
- Rønnestad, M. H., & Skovholt, T. M. (1993). Supervision of beginning and advanced graduate students of counseling and psychotherapy. *Journal of Counseling and Development*, 71, 396-405Rønnestad, M. H., & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on development. *Journal of Career Development*, 30(1), 5-44.
- Rorty, R. (1979). *Philosophy and the mirror of nature*. Princeton: Princeton University Press.

- Rosenthal, D., & Frank, J. D. (1958). The fate of psychiatric out-patients referred to psychotherapy. *Psychological Bulletin*, 53, 294-302.
- Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, 6(412-415).
- Roth, A., & Fonagy, P. (1996). What works for whom? A critical review of psychotherapy research. New York: Guilford Press.
- Rowe, C., & MacIsaac, D. (1991). Empathic attunement: The technique of psychoanalytic self psychology. New York: Aronson.
- Rubin, J. B. (1985). Meditation and psychoanalytic listening. *Psychoanalytic Review*, 72, 599-613.
- Russell, G. M., & Kelly, N. H. (2002). Research as interacting dialogic processes: Implications for reflexivity. *Forum: Qualitative Social Research*, 3(3).
- Russell, R. L. (1987). Psychotherapeutic discourse: Future directions and the critical pluralistic attitude. In R. L. Russell (Ed.), *Language in psychotherapy: Strategies of discovery* (pp. 341-351). New York: Guilford.
- Rustin, S. L. (1970). Therapist authenticity in group and individual psychotherapy with college students. *Journal of Contemporary Psychotherapy* 3(1), 45-50.
- Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55, 68-78.
- Ryle, G. (1949). *The concept of mind*. Chicago: University of Chicago Press
- Sackett, D. L., Rosenberg, W. M. C., Gary, J. A. M., Haynes, R. B., & Richardson, S. S. (1996). Evidence-based medicine: What it is and what it isn't. *British Medical Journal* 312, 71-72.
- Safran, J. D. (2003). Psychoanalysis and Buddhism as cultural institutions. In J. D. Safran (Ed.), *Psychoanalysis and Buddhism: An unfolding dialogue* Boston: Wisdom Publications.

- Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York: Guilford Publications.
- Salovey, P., & Mayer, J. D. (1990). Emotional Intelligence. *Imagination, Cognition and Personality* 9(3), 185-211.
- Saltzman, N., & Norcross, J. (Eds.). (1990). *Therapy wars: Contention and convergence in differing clinical approaches*. San Francisco: Jossey Bass.
- Sampson, E. E. (1989). The deconstruction of the self. In J. Shotter & K. J. Gergen (Eds.), *Texts of identity* (pp. 1-19). London: Sage.
- Sander, L. W. (2002). Thinking differently. *Psychoanalytic Dialogues*, 12(11-42).
- Sarason, S. B. (1982). *Psychology and social action: Selected papers*. New York: Praeger.
- Schacht, T. E. (1991). Can psychotherapy education advance psychotherapy integration? A view from the cognitive psychology of expertise. *Journal of Psychotherapy Integration*, 1, 305-320.
- Schafer, A. (1968). *Aspects of internalization*. New York: International Universities Press.
- Schmid, P. F. (2001). Authenticity: the person as his or her own author: Dialogical and ethical perspectives on therapy as an encounter relationship. And Beyond. In G. Wyatt (Ed.), *Congruence* (pp. 213-228). Ross-on-Wye, UK: PCCS Books.
- Schmitt Freire, E. (2006). Randomized controlled clinical trial in psychotherapy research: An epistemological controversy *Journal of Humanistic Psychology* 46, 323-335.
- Schneider, J. A. (2005). Dreaming the truth of experience: Heaven. *The Psychoanalytic Review*, 92 (5), 777-785.
- Schneider, P. (2008). Three experiential practices and their relation to psychoanalysis. *Psychoanalytic Psychology*, 25, 326-341.

- Schofield, J. (1993). Increasing the generalizability of qualitative research. In M. Hammersley (Ed.), *Social research: Philosophy, politics and practice* (pp. 200-225). London: Open University and Sage.
- Schofield, J. W. (2002). Increasing the generalizability of qualitative research. In A. M. Huberman & M. B. Miles (Eds.), *The qualitative research companion* (pp. 171-203). Thousand Oaks, CA: Sage.
- Schofield, M. J., Grant, J. A., Holmes, S., & Barletta, J. (2006). The Psychotherapy and Counselling Federation of Australia: How the federation model contributes to the field. *International Journal of Psychology*, 41(3), 163 - 169.
- Schön, D. (1983). *The reflective practitioner*. New York: Basic Books.
- Schön, D. (1987). *Educating the reflective practitioner*. San Francisco: Jossey Bass.
- Schön, D. (1992). Designing as reflective conversation with the materials of a design situation. *Research and Engineering Design*, 3(3), 131-148.
- Schore, A. N. (2009). Right brain affect regulation: An essential mechanism of development, trauma, dissociation, and psychotherapy. In D. Fosha, D. Siegel & M. Solomon (Eds.), *The healing power of emotion: Affective neuroscience, development and clinical practice* (pp. 112-144). New York W.W. Norton.
- Schulenberg, S. E. (2003). Approaching Terra Incognita with James F. T. Bugental: An interview and an overview of existential-humanistic psychotherapy *Journal of Contemporary Psychotherapy*, 33(4), 273-285.
- Schumacher, K. (2008). Constant comparisons. In K. Schumacher (Ed.), *Studies in symbolic Interaction* (Vol. 32, pp. 87-102): Emerald Book Chapter.
- Schwandt, T. A. (1994). Constructivist interpretivist approaches to human inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 118-137). Thousand Oaks, California: Sage.

- Schwandt, T. A. (1999). On understanding understanding. *Qualitative Inquiry*, 5(4), 451-464.
- Schwandt, T. A., & Halpen, E. S. (1988). Linking auditing and meta-evaluation: Enhancing quality in applied research. London: Sage.
- Schwartz, S. (2010). Wise-up: Restoring wisdom to universities. Sydney: Macquarie University Vice-Chancellor's Annual Lecture.
- Schwartz, S. H. (1994). Are there universal aspects in the structure and contents of human values? *Journal of Social Issues*, 50(4), 19-45.
- Schwebel, M., Schoener, G., & Skorina, J. K. (1994). *Assisting impaired psychologists* (Revised ed.). Washington, DC: American Psychological Association.
- Sciarra, D. T. (1999). *Multiculturalism in counselling*. Itasca, Illinois: F. E. Peacock Publishers, Inc.
- Scott, D. (1990). Practice wisdom: The neglected source of practice research. *Social Work*, 35(6), 564-568.
- Searle, J. (1969). *Speech acts*. New York: Cambridge University Press.
- Searle, J. (1983). *Intentionality: An essay in the philosophy of mind*. Cambridge, UK: Cambridge University Press.
- Sebeok, T. A., & Umiker-Sebeok, J. (1983). You know my method: A juxtaposition of Charles S. Peirce and Sherlock Holmes. In T. A. Sebeok, J. Umiker-Sebeok & U. Eco (Eds.), *The sign of three*. Bloomington, Indiana: Indiana University Press.
- Seeman, J. (2002). Looking back, looking ahead: A synthesis. In D. J. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: A handbook of research and practice* (pp. 617-636). Washington, DC: American Psychological Association.
- Seidman, E. (1989). A preferred route for substantive theorizing *American Journal of Community Psychology*, 17(5), 555-560.
- Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The consumer reports study. *The American Psychologist*, 50(12), 965-974.

- Sexton, T. L., Ridley, C. R., & Kleiner, A. J. (2004). Beyond common factors: Multilevel-process models of therapeutic change in marriage and family therapy. *Journal of Marital and Family Therapy* 30(2), 131-149.
- Shadish, W. R., Ragsdale, K., Glass, R. R., & Montgomery, L. M. (1995). The efficacy and effectiveness of marital and family therapy: A perspective from meta-analysis. *Journal of Marital and Family Therapy*, 21, 345-360.
- Shafer, A. (2003). *Mental health organizations and the problem of "management"* Paper presented at The Opus Conference Organizational and Social Dynamics: International Perspectives from Group Relations, Psychoanalysis and Systems Theory.
- Shank, G. (1998). The extraordinary ordinary powers of abductive reasoning *Theory and Psychology*, 8(6), 841-860.
- Shapiro, D. A., & Shapiro, D. (1982). Meta-analysis of comparative therapy outcome studies: A replication and refinement. *Psychological Bulletin*, 92, 581-604.
- Shapiro, F. (1995). Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures. New York: Guilford Press.
- Shapiro, S. L., Brown, K. W., & Biegel, G. M. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology*, 1(2), 105-115.
- Shapiro, T. (1981). Empathy: A critical re-evaluation. *Psychoanalytic Inquiries*, 1, 423-448.
- Shedler, J., & Westen, D. (1998). Refining the measurement of Axis II: A Qsort procedure for assessing personality pathology *Assessment*, 5, 333-353.
- Shoham-Salomon, V. (1990). Interrelating research processes of process research *Journal of Consulting and Clinical Psychology*, 58, 295-303.

- Shulman, B., & Watts, R. E. (1997). Adlerian and constructivist psychotherapies: Common ground and areas for dialogue. *Journal of Cognitive Psychotherapy, 11*, 181-194.
- Siegel, D. J. (1999). *The developing mind: How relationships and the brain interact to shape who we are*. New York: Guilford Press.
- Siegel, D. J. (2010). *Mindsight: The new science of personal transformation*. New York: Bantam.
- Siev, J., & Chambless, D. L. (2007). Specificity of treatment effects: Cognitive therapy and relaxation for generalized anxiety and panic disorders. *Journal of Consulting & Clinical Psychology, 75*(4), 513-522.
- Skovholt, T. M. (2005). The cycle of caring: A model of expertise in the helping professions. *Journal of Mental Health Counseling, 27*, 82-93.
- Skovholt, T. M., Hanson, M., Jennings, L., & Grier, T. (2004). A brief history of expertise. In T. M. Skovholt & L. Jennings (Eds.), *Master therapists: Expertise in therapy and counseling* (pp. 1-16.). Boston, MA: Allyn & Bacon.
- Skovholt, T. M., Hanson, M., Jennings, L., & Grier, T. (2004). Expertise in therapy and counseling. In T. M. Skovholt & L. Jennings (Eds.), *Master therapists: Exploring expertise in therapy and counseling*. (pp. 17-30). Boston, MA: Allyn & Bacon.
- Skovholt, T. M., & Jennings, L. (Eds.). (2004). *Master therapists: Exploring expertise in therapy and counseling*. Boston, MA: Allyn & Bacon.
- Skovholt, T. M., & Jennings, L. (2005). Mastery and expertise in counseling. *Journal of Mental Health Counseling, 27*, 13-18.
- Skovholt, T. M., Jennings, L., & Mullenbach, M. (2004). Portrait of the master therapist: the highly-functioning self. In T. M. Skovholt & L. Jennings (Eds.), *Master therapists: Exploring expertise in therapy and counseling* (pp. 125-146). Boston, MA: Allyn & Bacon.
- Skovholt, T. M., & Ronnestad, M. H. (1995). *The evolving professional self: Themes in counselor and therapist development*. New York: Wiley.

- Skovholt, T. M., & Rønnestad, M. H. (1992). Themes in therapist and counselor development. *Journal of Counseling and Development*, 70(4), 505-515.
- Skovholt, T. M., & Rønnestad, M. H. (1993). Supervision of beginning vs. advanced students. *Journal of Counseling and Development*, 71(396-401).
- Skovholt, T. M., & Rønnestad, M. H. (1995). The evolving professional self: Themes in counselor and therapist development. New York: Wiley.
- Skovholt, T. M., & Rønnestad, M. H. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development*, 30(1), 45-58.
- Skovholt, T. M., Rønnestad, M. H., & Jennings, L. (1997). The search for expertise in counseling. *Educational Psychology Review*, 9, 361-369.
- Sloane, R. B., Staples, E. R., Cristol, A. H., Yorkston, A. H., & Whipple, K. (1975). *Short-term analytically oriented psychotherapy vs behavior therapy*. Cambridge, Massachusetts: Harvard University Press.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology *Psychology & Health*, 11, 261-271.
- Smith, K. R. (2009). Psychotherapy as applied science or moral praxis: The limitations of empirically supported treatment. *Journal of Theoretical and Philosophical Psychology*, 29(1), 34-46.
- Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *The American Psychologist*, 32, 752-760.
- Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy*. Baltimore: John Hopkins University Press.
- Solovey, A. D., & Fraser, S. J. (2006). *Second-order change in psychotherapy: The golden thread that unifies effective treatments* Washington D.C.: American Psychological Association.

- Sommers-Flanagan, J., & Sommers-Flanagan, R. (2004). Counseling and psychotherapy theories in context and practice: Skills, strategies and techniques. New Jersey: Wiley and Sons.
- Specht, H. (1977). Theory as a guide to practice. In H. Specht & A. Vickery (Eds.), *Integrating social work methods* (pp. 28-35). London: George Allen and Unwin Press.
- Spence, D. (1982). Narrative truth and historical truth: Meaning and interpretation in psychoanalysis. New York: W. W. Norton.
- Spiegelberg, H., T. (1982). *The phenomenological movement: A historical introduction* (3rd ed.). The Hague: Martinus Nijhoff.
- Spinelli, E. (2002). The therapeutic relationship as viewed by existential psychotherapy: Re-Embracing the world *Journal of Contemporary Psychotherapy*, 32(1), 111-118.
- Spinelli, E. (2007). Practicing existential psychotherapy: The relational world. London: Sage.
- Spradley, J. (1979). *The ethnographic interview*. New York: Holt, Rinehart and Winston.
- Stake, R. (1978). The case study method in social inquiry. *Educational Researcher*, 7, 5-8.
- Stam, H. J. (1998). Personal-construct theory and social constructionism: Difference and dialogue. *Journal of Constructivist Psychology*, 11, 187-203.
- Starr, S. S. (2008). Authenticity: A concept analysis. *Nursing Forum*, 43(2), 55-62.
- Staudinger, U. M., & Baltes, P. B. (1996). Interactive minds: A facilitative setting for wisdom-related performances? *Journal of Personality and Social Psychology*, 71, 746-762.
- Steering Committee. (2002). Empirically supported therapy relationships: Conclusions and recommendations on the Division 29 Task Force. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist*

contributions and responsiveness to patients (pp. 441-443). Oxford: Oxford University Press.

Stern, D. N. (1985). *The interpersonal world of the infant*. New York: Basic Books.

Stern, D. N. (1998). The process of therapeutic change involving implicit knowledge: Some implications of developmental observations for adult psychotherapy. *Infant Mental Health Journal*, 19, 300-308.

Stern, D. N. (2004). The present moment in psychotherapy and everyday life. New York: W.W. Norton Ltd.

Stern, M. J. (1982). A note on obscurantism - the case of Aaron Green. *Contemporary Psychoanalysis*, 18, 646-651.

Stern, P. N. (1993). I can see: The transformative process of feminist awareness. *Health Care for Women International* 14(6), 7-8.

Stewart, A. J. (1990). The experience and meaning of work in women's lives. In H. Grossman & N. L. Chester (Eds.), *The experience* (pp. 261-271). Hillsdale, NJ: Lawrence Erlbaum.

Stiles, W. B., Barkham, M., Mellor-Clark, J., & Connell, J. (2008). Responsive regulation of treatment duration in routine practice in United Kingdom primary care settings: Replication in a larger sample. *Journal of Consulting and Clinical Psychology*, 76(2), 298-305.

Stiles, W. B., Shapiro, D. A., & Elliott, R. (1986). Are all psychotherapies equivalent? *The American Psychologist*, 41, 165-180.

Stiver, I. P., Rosen, W., Surrey, J., & Miller, J. B. (2000). *Creative moments in relational-cultural therapy*. Wellesley, MA: Stone Center Working Paper Series.

Stiver, I. P., Rosen, W., Surrey, J., & Miller, J. B. (2008). Creative moments in relational-cultural therapy. *Women & Therapy*, 31(2-4), 7-29.

Stolorow, R., & Atwood, G. (1992). Contexts of being: The intersubjective foundations of psychological life. Hillsdale, NJ: Analytic Press.

- Stolorow, R., Brandchaft, B., & Atwood, G. (1987). *Psychoanalytic treatment*. Hillsdale, NJ: The Analytic Press.
- Stolorow, R. D. (1993). The intersubjective approach: Commentary on Michael Tansey's "Psychoanalytic Expertise". *Psychoanal. Dialogues*, 3, 315-317.
- Stratton, P. (1997). Attributional coding of interview data: Meeting the needs of long-haul passengers. In N. Hayes (Ed.), *Doing qualitative analysis in psychology* (pp. 115-141). Hove, UK: Psychology Press.
- Strauss, A. (1987). *Qualitative analysis for social scientists*. Cambridge, UK: Cambridge University Press.
- Strauss, A. L., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. California: Sage Publications.
- Stricker, G. (1994). Reflections on psychotherapy integration. *Clinical Psychology: Science and Practice*, 1, 3-12.
- Stricker, G., & Gold, J. R. (1996). Psychotherapy integration: An assimilative, psychodynamic approach. *Clinical Psychology: Science and Practice*, 3, 47-58.
- Stricker, G., & Trierweiler, S. J. (1995). The local clinical scientist: A bridge between science and practice. *American Psychologist*, 50, 995 - 1002.
- Strong, S. R. (1968). Counselling: An interpersonal process. *Journal of Counselling Psychology*, 15, 215-224.
- Strupp, H. H. (1972). On the technology of psychotherapy. *Arch Gen Psychiatry*, 26, 270-278.
- Strupp, H. H. (1973). On the basic ingredients of psychotherapy. *Journal of Counseling and Clinical Psychology*, 41(4), 1-8.
- Strupp, H. H. (1980a). Success and failure in time-limited psychotherapy. *Arch Gen Psychiatry*, 37(8), 947-954.

- Strupp, H. H. (1980b). Humanism and psychotherapy: A personal statement of the therapist's essential values. *Psychotherapy: Theory, Research and Practice*, 17, 396-400.
- Strupp, H. H., Chasson, J. B., & Ewing, J. A. (1973). Longitudinal study of psychotherapy: Problem of methodology and quantification. In H. H. Strupp (Ed.), *Psychotherapy: Clinical research and theoretical issues* (pp. 424-476). New York: Jason Aronson.
- Strupp, H. H., & Hadley, S. W. (1979). Specific versus nonspecific factors in psychotherapy: A controlled study of outcome. *Archives of General Psychiatry*, 36, 1125-1136.
- Strupp, H. H., & Howard, K. J. (1992). A brief history of psychotherapy research. In D. K. Freedheim, H. J. Freudenberger, J. W. Kessler, S. B. Messer, D. R. Peterson, H. H. Strupp & P. L. Wachel (Eds.), *History of psychotherapy: A century of change* (pp. 309-344). Washington, DC: American Psychological Association.
- Sullivan, H. S. (1940). *Conceptions of modern psychiatry*. New York: Norton.
- Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York: Norton.
- Sullivan, M. F., & Skovholt, T. M. (2004). Master therapists' construction of the working alliance. In T. M. Skovholt & L. Jennings (Eds.), *Master therapists: Exploring expertise in therapy and counseling* (pp. 53-76). Boston, MA: Allyn & Bacon.
- Sullivan, M. F., Skovholt, T. M., & Jennings, L. (2005). Master therapists' construction of the therapy relationship. *Journal of Mental Health Counseling*, 27(1), 48-70.
- Surrey, J. (2005). Relational mindfulness. In C. K. Germer, R. D. Siegal & P. R. Fulton (Eds.), *Mindfulness and psychotherapy* (pp. 148-163). New York: The Guilford Press.
- Suzuki, L., Prendes-Lintel, M., Wertlieb, L., & A., S. (1999). Exploring multicultural issues using qualitative methods. In M. Kopala & L.

- Suzuki (Eds.), *Using qualitative methods in psychology* (pp. 49-62). Thousand Oaks, CA: Sage.
- Suzuki, L. A., Ahluwalia, M. K., Arora, A. K., & Mattis, J. S. (2007). The pond you fish in determines the fish you catch: Exploring strategies for qualitative data collection. *The Counseling Psychologist, 35*, 295-327.
- Symington, J. & Symington, N., (1996). *The clinical thinking of Wilfred Bion*, London: Routledge.
- Symington, N. (2006). *A healing conversation: How healing happens*. London: Karnac Books.
- Tabachnick, D. E. (2004). Techne, technology and tragedy. *Techne: Research in Philosophy and Technology (2003-2009)*, 7(3).
- Tallman, K., & Bohart, A. C. (1999). The client as a common factor: Clients as self-healers. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 91-132). Washington: American Psychological Association.
- Tallman, K., Robinson, E., Kay, D., Harvey, S., & Bohart, A. (1994). *Experiential and non-experiential Rogerian therapy: An analogue study*. Paper presented at the American Psychological Association.
- Taylor, C. A., & White, S. (2000). *Practicing reflexivity in health and welfare*. Buckingham: Open University Press.
- Tenenbaum, H. R., Crosby, F. J., & Gliner, M. D. (2001). Mentoring relationships in graduate school. *Journal of Vocational Behavior, 59*, 326-341.
- Thomas, M. L. (2006). The contributing factors of change in a therapeutic process. *Contemporary Family Therapy, 28*(2), 201-210.
- Thompson, C. (1945). Transference as a therapeutic instrument. *Psychiatry, 8*, 273-278.
- Thorndike, E. L. (1920). Intelligence and its uses. *Harper's Magazine, 140*, 227-335.

- Thorne, B. (1991). Person-centred counselling. Therapeutic and spiritual dimensions. London: Whurr.
- Thorne, B. (2003). *Carl Rogers* (2nd ed.). London: Sage.
- Timulak, L. (2008). *Research in psychotherapy and counselling*. Thousand Oaks, California: Sage Publications.
- Tolar, A., & Reznikoff, M. (1960). A new approach to insight: A preliminary report. *The Journal of Nervous and Mental Disease*, 130, 286-296.
- Townend, M., Iannetta, L. E., & Freeston, M. H. (2002). Clinical supervision in practice: A survey of UK cognitive behavioural psychotherapists accredited by the BABCP. *Behavioural and Cognitive Psychotherapy*, 30, 485-500.
- Tronick, E. Z. (2005). Why is connection with others so critical? The formation of dyadic states of consciousness: Coherence governed selection and the co-creation of meaning out of messy meaning making. In J. Nadel & D. Muir (Eds.), *Emotional development* (pp. 293-315). Oxford, England: Oxford University Press.
- Truax, C. B., & Carkhuff, R. R. (1967). *Towards effective counseling and psychotherapy*. New York: Aldine Atherton.
- Truax, C. B., & Mitchell, K. M. (1971). Research on certain therapist interpersonal skills in relation to process and outcome. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of Psychotherapy and Behavior Change* (pp. 299-344). New York: Wiley.
- Tryon, G., & Winograd, G. (2002). Goal consensus and collaboration. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 109-125). Oxford: Oxford University Press.
- Tsang, N. M. (2008). Kairos and practice wisdom in social work practice. *European Journal of Social Work*, 11(2), 131-143.
- Tudor, K., & Worrall, M. (1994). Congruence reconsidered. *British Journal of Guidance and Counselling*, 22(2), 197-206.

- Turner, V. (1967). *The forest of symbols: Aspects of Ndembu ritual*. Ithaca: Cornell University Press.
- Vacha-Haase, T., Davenport, D. S., & Kerewsky, S. D. (2004). Problematic students: Gate-keeping practices of academic professional psychology programs. *Professional Psychology: Research and Practice, 35*, 115-122.
- van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. New York: State University of New York Press.
- Velicer, W. F., Laforge, R. G., Levesque, D. A., & Fava, J. L. (1994). The development and initial validation of the Smoking Policy Inventory. *Tobacco Control, 3*, 347-355.
- Velicer, W. F., Richmond, R., Greeley, J., Swift, W., & Redding, C. R. (1992). A time series investigation of three nicotine regulation models. *Addictive Behaviors, 17*, 325-345.
- Vivino, B. L., Thompson, B. J., Hill, C. E., & Ladany, N. (2009). Compassion in psychotherapy: The perspective of therapists nominated as compassionate. *Psychotherapy Research, 19*(2), 157-171.
- Wade, G. H. (2002). A concept analysis of personal transformation. *Journal of Advanced Nursing, 28*(4), 713-719.
- Wainwright, D. (1997). Can sociological research be qualitative, critical and valid? . *The Qualitative Report, 3*(2), Accessed June 2006 from <http://www.nova.edu/ssss/QR/QR2003-2002/wain.html>.
- Walker, A. M., Rablen, R. A., & Rogers, C. R. (1960). Development of a scale to measure process changes in psychotherapy. *Journal of Clinical Psychology, 16*(1), 79-85.
- Wallerstein, R. (Ed.). (1992). *The common ground of psychoanalysis*. New Jersey: Jason Aronson.
- Wampold, B. E. (1997). Methodological problems in identifying efficacious psychotherapies. *Psychotherapy Research, 7*(1), 21-43.

- Wampold, B. E. (2001). The great psychotherapy debate: Models, methods and findings. Mahwah, NJ: Erlbaum.
- Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *American Psychologist*, 62(8), 857-873.
- Wampold, B. E., Ahn, H., & Coleman, H. L. K. (2001). Medical model as metaphor: Old habits die hard. *Journal of Counseling Psychology*, 48(3), 268-273.
- Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes." *Psychological Bulletin*, 122, 203-215.
- Wandersman A, Hallman W, & S., B. (1989). How residents cope with living near a hazardous waste landfill: an example of substantive theorizing. *American Journal of Community Psychology* 17(5), 531-547.
- Ward, C. C., & House, R. M. (1998). Counseling supervision: A reflective model. *Counselor Education and Supervision*, 38, 23-33.
- Ward, T., & Haig, B. (1997). Abductive reasoning and clinical assessment. *Australian Psychologist*, 32, 93-110.
- Watkins, E. C., Jr. (1997). Some concluding thoughts about psychotherapy supervision. In E. C. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 603-616). Brisbane John Wiley& Sons.
- Watson, J. C. (2002). Re-visioning empathy. In D. J. Cain (Ed.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 445-471). Washington, DC: American Psychological Association.
- Watson, J. C., & Greenberg, L. S. (1994). The alliance in experiential therapy: Enacting the relationship conditions. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 153-172). Oxford, England: Wiley.
- Watson, J. C., & Rennie, D. L. (1994). Qualitative analysis of client's subjective experience of significant moments during the exploration

of problematic reactions. *Journal of Counseling Psychology*, 41, 500-509.

Watson, N. (1984). The empirical status of Rogers' hypothesis of the necessary and sufficient conditions for effective psychotherapy. In R. F. Levant & J. M. Shlien (Eds.), *Client centred therapy and the person centred approach: New directions* (pp. 17-40). New York: Praeger.

Watts, R. E. (2003). Adlerian therapy as a relational constructivist approach. *The Family Journal: Counseling and Therapy for Couples and Families*, 11, 139-147.

Watzlawick, P., Beavin, J. H., & Jackson, D. D. (1967). *Pragmatics of human communication*. New York: Norton.

Weber, M. (1981). *General economic history*. New Jersey: Transaction Publishers.

Weeks, G. R., & L'Abate, L. (1982). *Paradoxical psychotherapy: Theory and practice with individuals, couples, and families*. New York: Brunner/Mazel.

Weinberger, J. (1993). Common factors in psychotherapy. In G. Stricker & J. R. Gold (Eds.), *Comprehensive handbook of psychotherapy integration*. (pp. 43-56). New York: Plenum Press.

Weinberger, J. (1995). Common factors aren't so common: The common factors dilemma. *Clinical Psychology: Science and Practice*, 2, 45- 69.

Weinberger, J., & Rasco, C. (2007). Empirically supported common factors. In S. T. Hoffman & J. Weinberger (Eds.), *The art and science of psychotherapy* (pp. 103-129). New York: Routledge.

Weiss, I., & Sampson, H. (1986). *The psychoanalytic process: Theory, clinical observations and empirical research*. New York: Guilford Press.

Welpton, D. F. (1973). Confrontation in the therapeutic process. In G. Adler & P. G. Myerson (Eds.), *Confrontation in psychotherapy* (pp. 249-269). New York: Science House.

- Welwood, J. (1999). Realization and embodiment: Psychological work in the service of spiritual development In G. Watson, S. Batchelor & G. Claxton (Eds.), *The psychology of awakening: Buddhism, science, and our day-today lives* (pp. 137-166). London: Rider.
- Werman, D. S. (1979). Chance, ambiguity, and psychological mindedness. *Psychoanalytic Quarterly*, 48(1), 107-115.
- Weschler, D. (1952). *The range of human capacities*. New York: Hafner.
- Westen, D., & Weinberger, J. (2004). When clinical description becomes statistical prediction. *American Psychologist*, 59, 595-613.
- Westra, H. (2004). Managing resistance in cognitive behavioural therapy: The application of motivational interviewing in mixed anxiety and depression. *Cognitive Behaviour Therapy*, 33(4), 161-175.
- Wechsler, I.S. (1952). The meaning of consciousness. *Bulletin New York Academy of Medicine*, 28, 739.
- Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research*, 7(1), 54-65
- Whelan, M. (1992). Hidden conversations. An introduction to communicative psychoanalysis: By David Livingston Smith. London Tavistock/Routledge.
- White, M. (2002). Addressing personal failure. *The International Journal of Narrative Therapy and Community Work*, 3, 33-76.
- Whyte, W. F. (1960). Interviewing in field research. In R. N. Adams & J. J. Preiss (Eds.), *Human organisation research* (pp. 352-374). Homewood, Illinois: The Dorsey Press.
- Wicker, A. W. (1989). Substantive theorizing. *American Journal of Community Psychology*, 17, 531-547.
- Wicker, A. W., & August, R. A. (1995). How far should we generalize?: The case of a workload model. *Psychological Science*, 6, 39-44.

- Wiersma, J. (1988). The press release. *Journal of Personality* 56(1), 205-238.
- Wilkins, P. (2000). Unconditional positive regard reconsidered. *British Journal of Guidance and Counselling*, 28(1), 23-36.
- Williams, E. N., & Morrow, S. L. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research*, 19(4 and 5), 576 - 582
- Willig, C. (2001). Qualitative research in psychology: A practical guide to theory and method. Buckingham: OUP.
- Winefield, H. R., Chandler, M. A., & Bassett, D. L. (1989). Tag questions and powerfulness: Quantitative and qualitative analyses of a course of psychotherapy. *Language in Society*, 18(1), 77-86.
- Winkler, R. W. (1973). Psychology as a social problem: How value-free is "objective psychology"? *Australian Psychologist*, 8(2), 120-127.
- Winner, E. (2000). The origins and ends of giftedness. *American Psychologist*, 55(1), 159-169.
- Wolak, A. (2009). Australian and Canadian managerial values: A review. *International Journal of Organizational Analysis*, 17(2), 139-159.
- Wolitzky, D. L., & Reuben, R. (1974). Psychological-mindedness. *Journal of Clinical Psychology*, 30(1), 26-30.
- Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford CA: Stanford University Press.
- Yalom, I. D. (1980). *Existential psychotherapy*. New York: Basic Books.
- Yin, R. (1989). *Case study research: Design and methods*. Newbury Park, CA: Sage.
- Yin, R. (1999). Enhancing the quality of case studies in health services research. *Health Service Research*, 34(5), 1209-1224.
- Yuen, S. P. (2004). *Hermeneutic social work practice*. River Edge: Global Publishing.

Zeira, A., & Rosen, A. (2000). Unraveling tacit knowledge? What social workers do and why they do it. *Social Service Review*, 74(1), 103-123.

Zweig, F. (1948). *Labour, life and poverty*. London: Gollancz.